Printed: 07/02/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E071		B. WING	 	07/02	2/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
GREELEY	COUNTY HOSPITAL	LTCU		D PO BOX 5, KS 6787			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	CCTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE	
F 000	INITIAL COMMENTS			F 000			
	The following citations represent the findings of a Health Resurvey 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.		s of a				
				F 157			
			tive s an in sician lent's , a ial				
			ative				
			ent's				
	The facility had a cen	not met as evidenced but sus of 26 residents with	n 16				
LABORATOR	Y DIRECTOR'S OR PROVIDER	K/SUPPLIER REPRESENTATI\	/L'S SIGNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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GREELEY	COUNTY HOSPITAL	LTCU		RD PO BOX				
			TRIBUN	NE, KS 6787	9			
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F 157	Continued From page 1			F 157				
	residents selected for sample. Based on observation, interview and record review, the facility failed to notify 1 of 16 residents' physicians when the resident experienced a minor injury as the result of a fall.							
			fall.					
	Findings included:							
	- Resident #2's clinical record included a 1-25-13 quarterly MDS (Minimum Data Set) assessment that identified the resident with no cognitive impairment and no falls since admission to the facility. A subsequent 4-27-13 quarterly MDS noted 1 fall with no injuries since the last assessment.		nent he					
	Review of the 7-25-13 Assessment) summar unsteady with ambula	ry described resident #2	2 as					
	Review of the 5-9-13 check resident often t	care plan directed staff o prevent falls.	f to					
	sustained an unwitner a.m. when he/she trip his/her wheelchair. R documentation reveal bruise to the right paliforearm, an abrasion his/her forehead. Rev revealed the resident treatment as a result the clinical record revenotified resident #2's minor injuries which of	led the resident receivem, a skin tear to the right to the right knee and to riew of the clinical recordid not require any of this fall. Further reviewealed no evidence staff physician of the fall with occurred on 4-18-13.	ed a ht ord ew of f					
		13 at 3:00 pm revealed d him/herself from the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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GREELEY	COUNTY HOSPITAL	LTCU		RD PO BOX NE, KS 6787				
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F 157	TV room down one have sident did not use the straight back chair for he/she transferred him. During an interview of licensed nursing staff to notify the resident's. During an interview of administrative staff A charge nurses to notify a fall. Administrative mot notify the physicial sustained a fall with more recommendation. Review of the facility states, "In the event attending or on call plassessment warrants. The facility failed to not the straight to t	ght backed chair in the sallway in the facility. The bell on table beside rany assistance before im/herself. In 6-25-13 at 3:30 pm, and 6-26-13 at 2:30 pm, stated he/she expected for the family physician and an after resident #2 minor injuries on 4-18-13 at 3:30 pm, stated he/she expected for the family physician and after resident #2 minor injuries on 4-18-13 at 3:30 pm, stated he/she expected for the family physician and after resident #2 minor injuries on 4-18-13 at 3:30 pm, stated he/she expected for the family physician and the family physician is notified if the hysician is notified if the	ne the dicy all. d the after did 3.	F 157				
		OPRIVACY - OPENED MAIL right to privacy in writte uding the right to send a		F 170				
	The facility reported a 16 residents sampled Based on interview as	not met as evidenced be census of 26 residents d. nd record review the faction to receive the right to receive the received the rece	s with					

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		17E071		B. WING		07/0)2/2013		
	OVIDER OR SUPPLIER COUNTY HOSPITAL	LTCU	506 THII	DDRESS, CITY, STATE, ZIP CODE THIRD PO BOX 338 UNE, KS 67879					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE			
F 170	promptly and on Saturation Findings included: - The facility's undated information stated insend and receive man and receive	ed Resident Rights esidents have the right il promptly." on 6/25/13 at 1:30 p.m., that the facility does not sidents every Saturday. on 6/25/13 at 2:40 p.m., that activity assistant I is in the facility on most dup and delivered the right dawareness that the facent mail on Saturdays. on 6/25/13 at 4:30 p.m., yealed if Activity assistant facility on Saturdays, run 6/26/13 at 11:30 a.m. arevealed he/she lacked acility failed to deliver	ot M mail. cility nt M nail is	F 170					
	receive mail promptly 483.15(b) SELF-DET MAKE CHOICES	and on Saturdays.	то	F 242					
	schedules, and health her interests, assessinteract with member inside and outside the	right to choose activitie h care consistent with h ments, and plans of car s of the community botl e facility; and make cho or her life in the facility	nis or re; h nices						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
	17E07 ⁻			B. WING		07/02/2013		
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GREELEY COUNTY HOSPITAL LTCU				RD PO BOX E, KS 6787				
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F 242	Continued From page	e 4		F 242				
	are significant to the r							
	This Requirement is The facility reported a 16 residents selected included review of che Based on observation review, the facility fail sampled for choices t frequency/schedules. Findings included: - Resident #25 's 8/1 assessment identified to choosing between bath, or sponge bath Resident # 25's quart Set) assessment date resident had a BIMS of status) score of 15 wh cognition and he/she The resident performe living) independently	not met as evidenced by census of 26 residents for sample. The sample bices for 2 residents. In, interview and record ed to allow 1 of 2 resident eright to choose bath (Resident #25) 6/12 admission MDS I his/her preferences rea tub bath, shower, becas "very important". erly MDS (Minimum Dated 5/19/2013 revealed to brief interview for mention indicated intact did not exhibit behaviored ADLs (activities of dand required physical his for sample of the sample o	ents ing lated d tal he tal					
	part of the bathing ac	•						
	The CAA (Care Area Assessment) summary completed on 8/16/2012 revealed the resident required supervision and cueing with ADLs secondary to poor decision making ability and required 1 person assist with bathing.		nt					
	choice for time to get to bed at 10 p.m. The	ng frequency and choic	to go					

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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
GREELEY	COUNTY HOSPITAL	LTCU	506 THI	RD PO BOX	(338			
			TRIBUN	IE, KS 6787	9			
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F 242	resident # 25 "wants to decisions". The residerespond appropriately about his care and proposed propos	to make his/her own ent had the ability to and accurately to questeferences. In on 6/24/2013 at 1:41 pland Time), resident # 2 dependently through the born to a designated out the wore clean clothing at a dining room table. Care Staff N if he/she him/her a bath today. It is not a dining room table. Care Staff N if he/she him/her a bath today. It is not a dining room table. It is not a dining room table in 6/24/2013, at 1:41 p. It is not care Staff N told him to the work of the would like the extra Staff N told him dule was Monday, ay, 3 times per week. The first of a bath every other than 16/24/2013 at 1:41 p. In first of the staff I reported the staff I reported the staff I reported residual independently, except the care of the staff I reported residual independently, except the care of the staff I reported residual independently, except the care of the staff I reported residual independently, except the care of the staff I reported residual independently, except the care of the staff I reported residual independently, except the care of the staff I reported residual independently, except the care of the staff I reported residual independently, except the care of the staff I reported residual independently, except the care of the staff I reported residual independently, except the care of the staff I reported residual independently, except the care of the staff I reported residual independently, except the care of the staff I reported residual independently, except the care of the staff I reported residual independently in the staff I reported I repor	p.m. 25 e atside and 5 are The Direct II. " iss m. ke to m/her The er n. e aths dent for	F 242				
		oorted he/she was not ed shower on 6/24/2013	3 and					

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i '		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	was not provided a shall be admission record admission record admission record admission record lack to his/her bathing pre The facility failed to a choose bathing frequence the baths. 483.15(f)(1) ACTIVIT INTERESTS/NEEDS The facility must provof activities designed the comprehensive as	thower on 6/25/2013. In 6/26/2013, at 11:10 per C reported the nurse as conson of their choices related the Nurse C reported the cy would be documented. Review of resident #2 ked documentation related the resident #25 the right resident resident #25 the right resident resident #25 the right resident resi	ed to ed on 25 's ted ght to e/she e with s and	F 242			
	The facility had a cen residents selected to included review of activities (an individualized activities (an individualized activities) (an individualized	tivities for 3 residents. n, interview and record led to provide an ongoir (evening and weekend) vity program for 1 of the r activities. (#25)	ng and e 3				

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/02		
GREELEY COUNTY HOSPITAL LTCU 50			506 THIE	RD PO BOX E, KS 6787	(338			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 248	status) score of 12 whimpaired cognition. Tidentified activity prefinewspapers, magazir keeping up with newsgoing outside for fres." The assessment in group activities as "rown activities of Daily Live decision making ability activities of Daily Live decision making ability activities of Daily Live decisions, chooses to set for him/herself, erown activities dogs and wante visited the facility. The goal: "To make cares for as long as I depression to worsen Resident #25's care such as jazz music, go helping others, partier reading/writing, loves identified his/her favo Terrier (a breed of do had as a pet). The caresident preferred activity as identified activity interview of Activity Assidentified activity interview of Activity interview of Activity interview of Activity interview.	nich indicated moderate the assessment further erences of books, nes, music, animals/pet of favorite activities, and hair, all as "very impondicated the resident vinot very important". AAA (Care Area ry completed on 8/16/20 as having confusion a siting with staff. The resident cuing with ADLs ing) secondary to poor by. An dated 6/3/2013, identity to make his/her own of follow the routine he/s higoyed talking to people d to be notified if a dog the nursing care plan incidecisions in my life and can. I don't want my so invite me to activitie plan also included integrardening, reminiscing, s/social events, being outdoors, and rite animal as a Cairn g that the resident form are plan also indicated fivities in his/her room of the care of the c	s, I pritant ewed 012 and sident disident diside	F 248				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER STR		STREET ADD	RESS, CITY, STA	TE, ZIP CODE				
GREELEY COUNTY HOSPITAL LTCU				RD PO BOX NE, KS 6787				
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F 248	Resident #25 's June documented he/she a visits and watched TV refusals of games, triv reading magazines, a entry on 5/30/13 by a resident lacked intere and enjoyed keeping outside. Review of the June 20 revealed no evening a Monday through Frida barbecue scheduled a The calendar also inc Saturday at 2:00 p.m. with church scheduled During an observation resident #25 attended participated. An observation on 6/2 resident #25 sleeping p.m. he/she ambulate activity room area for During an interview or resident #25 reported as an activity. He report weekend activities. evening activity he/sh on a van ride to look a He/she verbalized "I During an interview of activity staff E reporter responsibility of startimovie activity. He/sh	e 2013 Activity Log accepted one on one day daily. The log also incivia, coffee/chat each we and church each week. Citivity staff stated the st in outings, coffee/chat to him/herself and goin 013 Activity Calendar activities scheduled from any, with the exception of at 5:30 p.m. on 6/28/20 aluded poker scheduled and a movie at 6:30 p.d each Sunday at 1:30 m on 6/25/2013 at 10:30 m on 6/2	nuded eek, An at g m fa 13. each .m. p.m. dively aled 30 n., ights ening y going ' TV. " n. the end at	F 248				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 1	LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		17E071		B. WING		07/0:	2/2013
	OVIDER OR SUPPLIER COUNTY HOSPITAL	. LTCU	506 THI	RESS, CITY, STA RD PO BOX E, KS 6787	K 338		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ULL	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
	equipment and staff of occurred. During an interview of Direct Care Staff Direct Ca	on 6/25/2013 at 10:15 a. eported staff did not cue activities. He/she state ke and stay in his/her room 6/25/2013 at 11:10 a. onfirmed the facility did nor weekend activities of enurse reported there was resident attendance of activities because the pen. orovide an individualized elect resident #25's need activities. SSMENT DINATION/CERTIFIED at accurately reflect the enust conduct or coordinate the appropriate in professionals. Bust sign and certify that leted.	.m., ed the coomm., not ner vas ed the coom.	F 248			
	willfully and knowingl	ly certifies a material an resident assessment is					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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GREELEY COUNTY HOSPITAL LTCU			506 THII	ESS, CITY, STA RD PO BO) E, KS 6787	K 338			
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F 278	subject to a civil mone \$1,000 for each asses willfully and knowingly to certify a material air resident assessment penalty of not more thassessment. Clinical disagreement material and false stated to the facility reported at 16 residents sampled to the facility reported at 16 residents sampled to the facility fail the 16 sampled reside community discharge findings included: Resident #30's 4/24 included orders to add on 4/24/13 for rehabil disease characterized onset of symptoms the hospital stay. The phediagnoses of a right he (broken bone of the unfemoral neck fracture that attached to the head on which 1 staff provides in which 1 staff provides will be a civil ties of in which 1 staff provides will be a civil ties of in which 1 staff provides will be a civil ties of in which 1 staff provides will be a civil to a civil ties of in which 1 staff provides will be a civil to a civil ties of in which 1 staff provides will be a civil to a civil ties of the civil ties of t	ey penalty of not more of sement; or an individually causes another individually assistant and a census of 26 residents for review. In interview, and recorded to accurately assessents related to falls and a (Resident #30) If 13 physician's orders mit the resident to the faitation after an acute (at by a relatively suddentat are usually severe) ysician's orders include at are usually severe.	I who dual ey or control of the cont	F 278				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM				A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/02	/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
GREELEY	COUNTY HOSPITA	L LTCU		RD PO BOX E, KS 6787			
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY O	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 278	fracture (broken born not indicate that the The MDS failed to re experienced a fall ei 6 months prior to ad the resident experie the fall. The MDS reactive plan to discharesident planned to or to another facility that the resident fell to indicate where the discharge, the MDS investigations into fall Resident #30's 6/20 to assist the resident half of the body if the assistance and walk The care plan report strength improved s goal to take care of assistance available. The care plan report to stay in the facility less then return to hembers helped president #30 reported without difficulty and of pain such as grim. During an interview resident #30 reported he/she fell while tryin walked to work and and right hip. The resident #30 reported he/she fell while tryin walked to work and and right hip. The resident #30 reported he/she fell while tryin walked to work and and right hip. The resident #30 reported he/she fell while tryin walked to work and and right hip. The resident #30 reported he/she fell while tryin walked to work and and right hip. The resident #30 reported he/she fell while tryin walked to work and and right hip. The resident #30 reported he/she fell while tryin walked to work and and right hip. The resident #30 reported he/she fell while tryin walked to work and and right hip. The resident #30 reported he/she fell while tryin walked to work and and right hip. The resident #30 reported he/she fell while tryin walked to work and and right hip. The resident #30 reported he/she fell while tryin walked to work and and right hip.	ne) labeled as "other" and resident broke his/her has port that the resident lither 1 month or between mission and failed to income fractured bones from the profession and failed to report it discharge to the commu. Due to the failure to incomprior to admission and failed to resident planned to did not trigger further alls or community dischard the with dressing his/her lose resident asked for the ted independent with a cated that the resident's ince admission and had his/her own needs with the fif the resident needed if the ted that the resident plan approximately 4 weeks is/her apartment after failed independently using a displayed no outward sides and the sides of the s	ip. 1 2 to licate of an icate of the nity dicate ailure staff or ane. a a connection or mily m. 0 cone igns MST, go, the connection or arm lick	F 278			

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 17E071 B. WING 07/02/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **GREELEY COUNTY HOSPITAL LTCU 506 THIRD PO BOX 338** TRIBUNE, KS 67879 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 278 F 278 Continued From page 12 his/her right hip. The resident reported he/she planned to return to his/her apartment after family members adjusted the shower "so I won't have to bend my leg up that high". During an interview on 6/26/13 at 10:50 a.m. MST, Administrative Nursing Staff B verified the resident's MDS lacked information about the fall with fractures prior to admission and plans to discharge to the community. The facility failed to assess resident #30's Admission MDS accurately related to his/her fall with fractures prior to admission and plans to discharge to the community. F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO F 280 SS=D PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

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	OVIDER OR SUPPLIER COUNTY HOSPITAL	LTCU		ESS, CITY, STA RD PO BOX E, KS 6787	(338			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 280	This Requirement is The facility reported a 16 residents sampled reviewed for falls. Based on observation review, the facility fail 4 sampled residents' falls. (Residents #19, Findings included: Resident #19's 11/5 Data Set) Assessment difficulty understanding understood with mode The MDS reported the transferred and move supervision of one stawalker. The MDS repwithout injury since the Resident #19's 2/9/13 Assessment reported understood others and understood with mode The MDS reported to an acute hospital of 5/30/13. The MDS resometimes understand made him/herself und impaired cognition. Tresident needed superside to the same transferred and the moderstand made him/herself und impaired cognition. Tresident needed supersident meeded supersident meed	not met as evidenced by census of 26 residents for review and 4 residents, in interview, and record ed to review/revise 3 of care plans to prevent full #29, and #2) 2/12 Annual MDS (Minimate reported the residenting others/made him/hererately impaired cognitie resident independent in bed, needed aff for toileting, and use corted the resident fell of the previous assessment is a Quarterly MDS the resident usually differently impaired cognitie resident independent in the resident independent in the resident independent in the resident independent in the resident left the factor of the resident left the factor of the resident left the factor of the resident left in 5/2/13 and returned of the resident independent independent independent in the resident left in the factor of the resident left in the factor of the resident left in the factor of the resident independent independent in the resident left in the factor of the resident left in the factor of the resident independent in the resident left in the factor of the fa	s with ents f the urther mum had reelf on. ly d a once t. on. ly d a st efficility on hees	F 280				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/0	02/2013	
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE				
GREELEY	COUNTY HOSPITAL	LTCU	506 TH	RD PO BOX	(338			
			TRIBU	NE, KS 6787	9			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 280	Continued From page	e 14		F 280				
. 200	staff for transfers, and one staff for toilet use resident used a walke experienced no falls s	d extensive assistance of the MDS reported the and a wheelchair and since the last assessment	e I ent.	. 200				
	Assessment) summar stated he/she had a v pushed her from his/h resident to fall withou CAA reported the res falling due to use of n Seroquel (an antipsyc	2 Falls CAA (Care Area ry reported the resident ivid dream that a snake her chair which caused t injury on 10/13/12. The ident posed as high rish hultiple medications such chotic medication) and I) and independent use	e the ne k for ch as Lasix					
	Resident #19's 6/13/13 Falls CAA summary reported the resident experienced no recent falls but posed as high risk for falls due to recent changes in his/her functioning ability and needed more assistance with activities of daily living. The CAA reported that staff utilized an alarm to activate if the resident attempted to transfer him/herself.							
	6/4/13, informed staff assessment ranked a resident as a high risk informed staff the resin the past and if the residual to the charge nurse, a closely when he/she walker as staff may neassist the resident to reported the resident urinary tract infections risk of falling due to in	of for falls. The care play dent experienced a few resident complains of few lent's vital signs, report and watch the resident walked independently weed to use a gait belt to	fall n v falls eeling this vith a ping er					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		17E071		B. WING		07/0	02/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GREELEY	COUNTY HOSPITAL	LTCU	506 THI	RD PO BOX	(338		
			TRIBUN	IE, KS 6787	9		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	Continued From page	e 15		F 280			
Γ 200	resident's room free of reach, and ensure the non-slip surfaces. The keep the resident's be the bed wheels locked slipping out of bed. The update on 5/31/13 insteads to assist the resident sit-to-stand lift if neces use of gait belts with the listed on the care plar and reported the resident staff next to the bed". The mention of the resident lacked an intervention 10/13/12 and 6/22/13. Review of resident #1	of clutter, call light withing resident's footwear has a care plan instructed to the care plan instructed to the care plan included a structing that 2 staff new with transfers and to us sary but lacked mention included the 10/13/12 dent "was found on flood The care plan lacked in to prevent further falls in the care plan lacked in the care further falls in the care plan lacked in the care plan lacked in the care further falls in the care plan lacked in the care further falls in the care plan lacked in the care further falls in the care plan lacked in the care further falls in the care plan lacked in the care further falls in the care plan lacked in the care further falls in the care plan lacked in the care further falls in the care plan lacked in the care plan lac	ad and and and and and and and and and a	r 200			
	that staff found the rehis/her left side on 6/2 nurse's note reported and the resident state and missed the bed". revealed staff notified resident's fall of the 6 assessed the resident for the next 72 hours. During an observation MST, Direct Care State Staff C assisted the refailed to use a gait be resident held the bath transfer and stood in a not stand up or sit downs.	t's vital signs and condi	org on ury opped ition .m. sing but The he ould sting				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/0	2/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	ATE, ZIP CODE		
GREELEY	COUNTY HOSPITAL	LTCU		RD PO BOX E, KS 6787			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 280	observations revealed on the back of the b	d a gait belt hung on a lathroom door. In 6/26/13 at 11:01 a.m. Nursing Staff B reported tharge nurse to update retention to prevent furth icy", last revised on 2/2 ke "necessary changes care shall be implement esident falls. Eview/revise resident #'n 10/13/12 and 6/22/13 all record included a 1-2 num Data Set) assessmident with no cognitive and no falls since admissequent 4-27-13 quarterly no injuries since the late of	d the the her 21/08, sto hted 19's sto 25-13 hent ssion by state 2 as ty of the ck ck are lates: did	F 280			
	not state when facility	staff initiated the abov	re				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/0	2/2013	
	OVIDER OR SUPPLIER COUNTY HOSPITAL	LTCU		ESS, CITY, STA RD PO BOX E, KS 6787	(338			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	I .	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 280	sustained on 2-4-13 facility failed to provid documentation related Review of the clinical sustained an unwitne he/she tripped over the wheelchair. Review or revealed the resident right palm, a skin tear abrasion to the right ke forehead. Further review of the intervention sheet in the intervention to "encounceded" after falls on Review of the nurses p.m. revealed staff for as a result of a fall that cm laceration on his/finedical treatment. Observation on 6-24-resident #2 transferre wheelchair to a straig TV room down one had resident did not use the	In a fall risk assessment as high risk for falls. In notes lacked ding the fall resident #2 Although requested, the le evidence of additional dot this fall on 2-4-13. In record revealed the resisted fall on 4-18-13 where wheel of his/her fadditional documental received a bruise to the tothe right forearm, and the resident's chart with surage to ask for help where and to his/her and to ask for help where the fact of the fall was and 4/18/13. In notes on 6-10-13 at 12 and resident #2 on the fact resulted in a 2 cm x for head that did not record the fall was at 3:00 pm revealed the highest from the highlight in the facility. The bell on table beside from any assistance before	ail sident een tion e n a fall an hen 2:00 floor 0.3 quire	F 280	DEFICIENCY 1 TO THE PROPERTY OF THE PROPERTY O			
	During an interview o	n 6-25-13 at 3:30 p.m.,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E071 B. WING 07/02/201		2/2013			
	OVIDER OR SUPPLIER		STREET ADDRE				
				RD PO BOX E, KS 6787			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 280	licensed nursing staff to investigate the cau new intervention after During an interview of administrative staff A staff to update the call interventions after each A confirmed staff failed care plans with new in sustained on 2-4-13, and Review of the facility's states, "Necessary of care shall be impled. The facility failed to use interventions to help president #2. - Resident #29's., 4/1 (minimum data set) resident #2. - Resident #29's., 4/1 (minimum data set) resident #2. - Resident #29's., 4/1 (minimum data set) resident #2. - Resident #29's., 4/1 (minimum data set) resident #29 was not without staff assist what standing position, turn from surface to surface revealed the resident motion in upper or low continent of bladder a also revealed the resident #29's CAA (Resident #29's CAA).	C stated it is facility pose of the fall and initiate each fall. In 6-26-13 at 1:30 p.m., stated he/she expected re plan with new ch fall. Administrative need to update resident #2 neterventions after falls 4-18-13 or 6-10-13. Is fall policy dated 2-21-thanges to the resident mented immediately". In policy dated 2-21-thanges to the resident mented immediately or event further falls for a data of the care plan with the policy dated a BIMS (brief tatus) which indicated	red and and and and and and and and and an	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/0	02/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
GREELEY	COUNTY HOSPITAL	LTCU	506 TH	IRD PO BOX	C 338			
				NE, KS 6787				
2411.15	OLIMANA DV. OT	FATEMENT OF DEFICIENCIES			Г	COORDECTION	(X5)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE	
F 280	Continued From page	e 19		F 280				
		at risk for falls due to a						
		a (a progressive mental						
	_	d by failing memory and						
		a new admission to the						
	facility. The assessm							
		alarm placed, that stat	ff					
	needed to visually che							
	frequently and assist	with activities of daily li	ving.					
	The C/4/40 manifes all man		: d =4					
		ursing care plan for res						
		any resident newly adn considered at risk for fa						
		es and slippers to ensu						
		surface and to keep be						
	-	care plan noted that on	J 111					
	•	slid out of chair when hi	s/her					
		taff that the resident ha						
		r room, therefore no ala						
		esident #29. The care						
	=	ad been notified to let t	-					
	_	en they are leaving the						
	building. The nursing	care plan further revea	aled					
	to staff on 6/4/13 that	resident #29 ambulate	d					
	with two assist and ha	ad an alarm placed on						
	wheelchair, recliner a	nd bed. The care plan						
		o prevent future falls af	ter					
		0/13, 4/21/13, 4/27/13,						
		/13, 5/24/13 ,5/26/13, 6	/4/13,					
	6/8/13, 6/9/13, and 6	/20/13.						
	Resident #20's fall as	sessment dated 2/17/1	3					
	identified resident as		5					
	isontinos rodiscrit do	ingit tion for fails.						
	According to resident	#29's physician standir	ng					
	•	ed the staff should notify	•					
		or causes, fill out the fal						
		in the medical record a						
		OON (director of nursing						
		,						
	Review of the fall inve	estigation form revealed	d that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/0	02/2013	
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
GREELEY	COUNTY HOSPITAL	LTCU		IRD PO BO) NE, KS 6787				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	5/3/13, 5/26/13, 6/9/1 the clinical record reviof the care plan to present the care immediately. Observation on 6/25/#29 sat at the dining ron floor and a beeper resident's wheel chair. During an interview of care staff D revealed placed in wheelchair, and staff should keep well-populated areas. That resident #29 attentions that resident #29 attentions that resident #29 attentions that resident in eye contact further revealed that a resident in eye contact further revealed that a nurses should update appropriate intervention. During an interview of Administrative nurse of expected the charge in plan with an appropriate and confirmed the updated.	10/13, 4/20/13, 4/27/13, 3, and 6/18/13 and reviered no evidence of upperent future falls. The event future falls of that if a fall occurs to ages to the resident plants at 8:06 a.m., Reside from table, with feet resident manner and noted in the resident #29 had all recliner or bed at all ting the resident in a staff D further revealed mpts to transfer at he/she had a hard ting the fall the chart of the time of fall the chart the time of fall the chart had a hard the care plan with an on. The 6/26/13 at 11:16 a.m. A revealed that he/she nurse to update the care ate intervention following the care	ew of pdate of n of nt sting direct tarms nes ed me #29 e B arge , e g a	F 280				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/02	2/2013
	OVIDER OR SUPPLIER COUNTY HOSPITAL	LTCU		RD PO BO) E, KS 6787	(338		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 280	Continued From pag- care plan with approp strategies after multip	riate fall prevention		F 280			
	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES			F 323			
	as is possible; and ea	as free of accident haz					
	The facility had a cen sampled for review.		n 16 eview				
	review, the facility fail environment remaine for 6 of 6 cognitively i mobile residents whe	n, interview, and record ed to ensure the reside d free of accident/haza mpaired, independently n staff stored potentially in areas accessible to	ents' rds / y				
	review, the facility als resident environment accident/hazards (unl leading to unsecured alcove area not within	remained free of locked dining room doo concrete stairs and an n visualization of staff) f ed as cognitively impair	ors				
		n, interview, and record o failed to ensure 3 of 4	I				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	17E071 B. WING			07/02	2/2013		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE		
				RD PO BOX E, KS 6787			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From page	e 22		F 323			
	residents sampled for falls received adequate supervision to prevent accidents/falls. (#19 , #29, #2)						
	Findings included:						
	MST (Mountain Stand common shower room in the lock of the door contained the followin * Power clean pre-dis labeled "Keep out of r * Cid-a-I II disinfectar labeled "Keep out of r * 3m HB Quat disinfespray bottle, labeled "An observation on 6/2 revealed the common without the key in the During an interview of administrative nurse of expected staff to lock	ing unsecured chemicals sinfectant, 1 gallon, 1/2 reach of children." Int cleaner, 1 gallon, full reach of children." Interest cleaner, full 1 literest cleaner, full 2 literest cleaner, full 1 lit	the cated s: 2 full, T				
	Although requested, t	he facility failed to prov or chemical storage.	ride a				
	<u>-</u>						
		2/13 quarterly MDS ssessment revealed the (brief interview for men					

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I' '	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	17E071 B. WING 07/02/20		2/2013			
NAME OF PROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
			D PO BOX E, KS 6787			
(X4) ID SUMMARY STATEMEI PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	T BE PRECEDED BY F	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROPERTY)	D BE	(X5) COMPLETION DATE
F 323 Continued From page 23 status) score of 5 which indicognitive impairment and with the corridor and his/her room. Resident #11's 11/9/12 CAA assessment) summary for of the resident had confusion to referred to nurses' notes for episodes of confusion. The stated the resident often looks on or parents". The 5/20/13 nursing care pliedentified the resident had a stated, "I am very forgetful at The care plan further stated for his/her parents and for a resident's mobility care plan around the facility independ supervision to go places the building." An observation on 6/24/13 at (Mountain Standard Time) is area revealed two sets of ur leading to an enclosed concarea. The courtyard had at a area that led to a cement state observation, the gate the leasily, making the stairway residents. The courtyard als alcove area with a barbecue of the building, not within visid dining room. During an observation on 6/MST, resident #11 stood by doors in the dining room are and stood in the doorway for came back inside.	ralked independer m. A (care area cognitive loss stat to place/time and r documentation of e CAA summary a cked for his/her "y lan for resident # a memory problem andeasily confurt the resident look a "lost boy". The n stated, "I ambulated at are not here in lat 10:45 a.m. MS in the dining room nlocked double dicrete courtyard/pametal gate/fenced airway. During the dothe stairs operasily accessible so had a cementic grill on the west sualization from the control of the double ea, opened the double	red of also young 11 m and used". ked ate the The oors atio description and the ened ened ened ened ened ened ened en	F 323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/0	02/2013	
	OVIDER OR SUPPLIER COUNTY HOSPITAL	LTCU	506 THII	RD PO BOX E, KS 6787	(338	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FILES OF LISC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From page	e 24		F 323				
	An observation on 6/2 revealed the gate to the area in a secured, local direct entry also revealed the dinicultural cognitively impaired, it residents with access a cognitively impaired, it residents with access and direct care staff A staff bolted the gate to ensure residents with access and interview on 6/26/direct care staff H reverse frequently went in to the area unattended. On 6/26/13 at 3:00 p.m. G stated he/she was alcove area in the courty He/she stated the gate 6/26/13. The facility failed to end of accident/hazards for independently mobile facility courtyard. The	26/13 at 8:20 a.m. MST he stairway in the court ked position. In 6/25/13 at 5:30 p.m. It is stated the gate to the ard should be locked any room doors remained hit without constant. The facility identified 6 independently mobile to the facility courtyard in 6/26/13 at 8:30 a.m. It confirmed that maintened the stairs in the courty ould not have access to 13 at 10:14 a.m. MST we ealed resident #11 he dining room courtyal in MST maintenance statelling a gate to the	MST, and ed					
	cement alcove area o	led to concrete stairs and the west side of the visible to staff in the direction.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/0	2/2013
NAME OF DD	OVIDER OR SUPPLIER		STREET ADDE	RESS, CITY, STA	TE ZIP CODE		
	COUNTY HOSPITAL	LTCII		RD PO BOX			
GREELET GOORTT HOOFTIAL ETGG				E, KS 6787			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	room area Resident #19's 11/9	/12 Annual MDS (Minin		F 323			
	difficulty understandir understood with mode The MDS reported the transferred and move supervision of one sta walker. The MDS rep	nt reported the resident ng others/made him/her erately impaired cogniti e resident independent d in bed, needed aff for toileting, and use ported the resident fell of the previous assessment	self on. ly d a once				
	The MDS reported the moved in bed, transfer	the resident usually	ly d a				
	Status MDS reported to an acute hospital of 5/30/13. The MDS resometimes understand made him/herself undimpaired cognition. Tresident needed superstaff for bed mobility, staff for transfers, and one staff for toilet user resident used a walked experienced no falls staff.	Ids others and sometimal derstood with severely the MDS reported the ervision assistance of or diextensive assistance of extensive assistance of the MDS reported the and a wheelchair and since the last assessment.	esility person ne ne ne ne ne ne ne ne ne				
	Assessment) summar stated he/she had a v	2 Falls CAA (Care Are ry reported the resident rivid dream that a snake ner chair which caused	t e				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/	02/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
	COUNTY HOSPITAL	LTCU	506 TH	IRD PO BOX	(338			
				NE, KS 6787				
(X4) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN C	NE CORRECTION	(X5)	
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	COMPLETION DATE	
F 323	Continued From pag	e 26		F 323				
	resident to fall withou CAA reported the res falling due to use of n Seroquel (an antipsyo	t injury on 10/13/12. The ident posed as high rish nultiple medications suchotic medication) and lot and independent use	k for ch as Lasix	,				
	reported the resident but posed as high risk changes in his/her fur more assistance with CAA reported that sta	3 Falls CAA summary experienced no recent of for falls due to recent nctioning ability and new activities of daily living aff utilized an alarm to tattempted to transfer	eded					
	6/4/13, informed staff assessment ranked a resident as a high risk informed staff the resident to the past and if the idizzy to take the resident to the charge nurse, a closely when he/she walker as staff may n assist the resident to reported the resident urinary tract infections risk of falling due to in confusion. The care resident's room free or reach, and ensure the non-slip surfaces. The keep the resident's bethe bed wheels locked slipping out of bed. Tupdate on 5/31/13 insto assist the resident	c for falls. The care plated a few resident experienced a few resident complains of few dent's vital signs, report and watch the resident walked independently weed to use a gait belt to	fall n v falls eeling this vith a ping er the n ad to n and rom an eded se a					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION	(X3) DATE S COMPL	
		17E071		B. WING		07	/02/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
GREELE	COUNTY HOSPITAL	LTCU		RD PO BOX E, KS 6787			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F R LSC IDENTIFYING INFORMA	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	use of gait belts with listed on the care pla and reported the resistaff next to the bed" mention of the reside lacked an intervention 10/13/12 and 6/22/13. Review of resident # form reported the resident form reported as high risk form reported as high risk form reported staff noted a resident's nose with a small abrasion on the buting the resident form for the resident stated he/she form form for the resident form for the resident form of the resident form of the resident form of the resident form of the resident state and missed the bed" revealed staff notified resident's fall of the form of the form of the resident's fall of the form	transfers. Dates of falls in included the 10/13/12 in included the 10/13/12 ident "was found on flood. The care plan lacked ent's fall on 6/22/13 and in to prevent further falls 3. 19's "Fall Risk Assessmandent scored as "11" or 6/13, and "20" on 6/17/1 ints who scored 7 or higher falling. 19's nurses' notes revealent on the floor laying or 10/13/12 at 1:15 a.m. Martine). The nurse's note a facial tissue in the assmall amount of bloods the left side of his/her nurse's note report he saw snakes in the cloust have been dreamings revealed the physician received notification of fassessed the resident tion for the next 72 hours 19's nurses' notes revealed the floor laying 19's nurses' notes revealed the floor laying 19's nurses' notes revealed the physician and the 19's nurses' notes revealed the floor laying 19's nurses' notes revealed the physician and the 19's nurses' notes revealed the physician and the 19's 19's fall and staff and the 19's 19's 19's 19's 19's 19's 19's 19's	e fall or by s on nent" 13 with ther aled 15 ST 15 e 14 and 15 seet 15 seet 15 seet 16 and 17 seet 18 seet 19 seet	F 323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			E CONSTRUCTION	(X3) DATE SU COMPLE	
		17E071		B. WING		07/0	02/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	-	
GREELEY	COUNTY HOSPITA	L LTCU		RD PO BOX E, KS 6787			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Review of resident # standing orders reversions any fall, if no appare out a communication to the physician. Vit shift for 72 hours on If the fall occurs, not causes of the fall, countries, follow Glasgow Coma Scaulertness] every 15 revery hour for 4 hour remaining 72 hours. During an observation MST, Direct Care St staff C assisted the failed to use a gait be resident held the battransfer and stood in not stand up or sit do by holding under the observations revealed on the back of the bouring an interview Direct Care Staff I reverbal report that the could not recall whe bed activated, and the activated, and the tattempted to transfer reported he/she wor few months, did not other falls, and staff wheelchair and bed for falling. During an interview During an interview of the falls, and staff wheelchair and bed for falling.	#19's 4/5/13 physician's ealed "notify the physician ent injury call the clinic on a sheet and fax it to the eal signs are to be done on non-inury falls or accide tify the physician, evaluated by the physician, evaluated by the Director of Nursing. The Director of Nursing. The Director of Nursing. The Director of Nursing is up with vital signs include [a scale to evaluate eminutes for one hour, the properties of the period of the pe	r fill clinic every ents. te the neet For ding en nee .m. sing but The he could sting .d. loop .d. loo	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	17E071		B. WING		07/0	02/2013
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GREELEY COUNTY HOSPITAL LT	тси	506 THI	RD PO BOX	(338		
		TRIBUN	IE, KS 6787	9		
PRÉFIX (EACH DEFICIENCY N	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323 Continued From page 2 transferred the resident he/she could not find on Staff D recalled that staft the floor recently and ha of last year, neither fall volume and interview on 6 MST, Licensed Nursing facility expected staff to helping resident #19 to the During an interview on 6 MST, Administrative Nurfacility expected the charcare plan with an interventials. Staff B reported the assess a resident's neur staff suspected a head into the fact no one witness 10/13/12 and 6/22/13 factognition fluctuated, staff possible head injury with the facility posed a risk to factility posed a risk to factility posed a risk to factility posed a risk to fact environment and predisp will complete each residinterventions to prevent assessments of the ability how much assistance the toileting. The policy instructed staff to use be residents who posed as "necessary changes to the shall be implemented im resident falls. The policy related to unwitnessed firelated to unwit	with use of a gait beline prior to the transfer off found the resident of ad not fallen since the with injuries. 6/25/13 at 12:36 p.m. of Staff C reported the utilitize a gait belt who transfer. 6/26/13 at 11:01 a.m. or sing Staff B reported arge nurse to update the facility expected starological condition on injury and agreed that seed resident #19's alls and the resident's aff should suspect a should suspec	at but r. con e end at the	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/0	02/2013	
	OVIDER OR SUPPLIER COUNTY HOSPITAL	LTCU	506 THII	RESS, CITY, STA RD PO BOX E, KS 6787	(338	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From page	e 30		F 323				
		pervision to prevent ed to utilize a gait belt o iled to revise the reside						
	severely impaired cog assessment also reve supervision with trans toileting. The assessr resident #29 was not without staff assist wh standing position, turn from surface to surface revealed the resident motion in upper or low continent of bladder as	evealed a BIMS (brief tatus) which indicated	nd nat nilize ng to er so ge of ment					
	summary dated 4/14/ that the resident was diagnosis of dementia disorder characterize confusion) and being facility. The assessm resident had a motion needed to visually che frequently and assist The 6/4/13 revised n #29 alerted staff that to the facility should	alarm placed, that stat	eting d d e ff ving. ident nitted					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/0	2/2013	
	ROVIDER OR SUPPLIER / COUNTY HOSPITAL	LTCU		ESS, CITY, STA RD PO BOX E, KS 6787	(338			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	they have a non-slip s lowest position. The of 4/20/13 the resident s family did not notify sibeen placed in his/he had been placed on revealed that family he facility staff know whe building. The nursing to staff on 6/4/13 that with two assist and he wheelchair, recliner a lacked interventions t falls sustained on 4/1 5/3/13 (two falls), 5/7/6/8/13, 6/9/13, and 6 Resident #29's fall as identified resident as According to resident orders if a fall occurre physician, evaluate for evaluation sheet, put make a copy for the E Review of the fall investigation on the care plan to present the care plan to present the care plan to present the care immediately. Observation on 6/25/429 sat at the dining in the care immediately.	surface and to keep bed care plan noted that on slid out of chair when hi taff that the resident har room, therefore no also esident #29. The care ad been notified to let the they are leaving the care plan further reveal and an alarm placed on a larm placed on not bed. The care plan opervent future falls af 0/13, 4/21/13, 4/27/13, 4/27/13, 5/24/13, 5/26/13, 6/20/13. **sessment dated 2/17/1 "high risk" for falls. **#29's physician standing the staff should notified the staff should notified the medical record and DON (director of nursing estigation form revealed 10/13, 4/20/13, 4/27/13, 3, and 6/18/13 and reviewed and one evidence of u	is/her id arm plan the aled id ifter i/4/13, and ifter il ind ind if iew of pdate of in of ient sting	F 323				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/0	2/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•	
				RD PO BO) E, KS 6787			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	's wheel chair. During an interview o direct care staff D revalarms placed in whe times and staff should well-populated areas. that resident #29 atte herself/himself and the judging distance. During an interview of Administrative staff B liked to self-transfer a resident in eye contact further revealed that a nurses should update appropriate intervention. During an interview of Administrative nurses expected the charge of plan with an appropriate intervention. The facility failed to imprevention strategies multiple falls on 4/10/(two falls), 5/7/13, 5/2 6/8/13, 6/9/13, and 60-1 Resident #2's clinic quarterly MDS (Minimathe resident with no contact of the staff of the s	n 6/25/13 at 4:24 p.m., realed the resident #29 elchair, recliner or bed dikeep the resident in a. Staff D further revealed mpts to transfer at he/she had a hard time of 6/26/13 at 10:20 a.m. revealed that resident and staff should keep that. Administrative staff at the time of fall the chart the care plan with an on. In 6/26/13 at 11:16 a.m. A revealed that he/she nurse to update the care atte intervention following care plans were not expending the plans were not expending the fall that the fact at a fire resident #29 sustant 13, 4/21/13, 5/26/13, 6/4/13, 6/20/13. In all record included a 1-2 and plans a fact of the facility. A subsect of some of the facility. A subsect of some of the facility. A subsect of some of 1 fall with no	at all ed me , # 29 e B arge , re 10 a 25-13 tified d no	F 323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/0	02/2013	
	OVIDER OR SUPPLIER COUNTY HOSPITAL	LTCU	506 THII	ESS, CITY, STA RD PO BO) E, KS 6787	(338			
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F 323	Review of the 7-25-13 Assessment) summal unsteady with ambulate Review of the 5-9-13 fall prevention strategy recliner, need reminds floor, check shoes an surrounding area to k often, and lock brakes plan listed the resider 2-4-13, 3-1-13, and 4 not state when facility interventions. Review of the 4-27-13 identified resident #2 Review of the nurses documentation regard sustained on 2-4-13. facility failed to provide documentation related. Review of the clinical sustained an unwitner he/she tripped over the wheelchair. Review of revealed the resident right palm, a skin tear abrasion to the right key forehead. He/she did treatment after the fall. Further review of the intervention sheet in the intervention to "enconeeded" after falls or needed" after falls or needed need needed need needed n	a fall CAA (Care Area ry described resident #2 ation. care plan listed a varieties such as keep bell ber not to pick up things d slippers, check eep free of clutter, check eep free of clutter, check eep free of clutter, check et and the following described as a staff initiated the abovers as a staff initiated the resident and the fall on 2-4-13. The care plan listed a varieties and the fall on the	ty of peside off ck are ates: did e sident pen ation e n	F 323				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI		1 ' '	E CONSTRUCTION	(X3) DATE S COMPLI	
		17E071		B. WING		07.	/02/2013
	OVIDER OR SUPPLIER COUNTY HOSPITA	AL LTCU		ESS, CITY, STA RD PO BOX E, KS 6787	338		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMA		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329 SS=E	pm revealed staff for as a result of a fall cm laceration on his medical treatment. Observation on 6-2 resident #2 transfer wheelchair to a stratory room down one resident did not use straight back chair he/she transferred. During an interview licensed nursing state investigate the conew intervention afformed staff to update the interventions after a A confirmed staff for care plan with new sustained on 2-4-1. Review of the facility states, "Necessary of care shall be imported."	cound resident #2 on the fithat resulted in a 2 cm x is s/her head that did not resident #2.4-13 at 3:00 pm revealed red him/herself from the aight backed chair in the signal backed in the signal backed signal b	equire small he the c blicy e a d nurse 2's -08 plan	F 329			
	unnecessary drugs drug when used in	g regimen must be free f An unnecessary drug is excessive dose (including or for excessive duration	s any g				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/0	02/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
	COUNTY HOSPITAL	LTCU	506 THI	RD PO BOX	(338			
			TRIBUN	IE, KS 6787	9			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	without adequate more indications for its use; adverse consequence should be reduced or combinations of the resident, the facility may be a diagnosed and do record; and residents drugs receive gradual behavioral intervention.	nitoring; or without adea; or in the presence of es which indicate the do discontinued; or any easons above. ensive assessment of a nust ensure that resider ntipsychotic drugs are reless antipsychotic drug to treat a specific condicumented in the clinical who use antipsychotic I dose reductions, and	nts not	F 329				
	The facility reported a residents reviewed for Based on observation review, the facility fail residents did not recemedications, when stabehaviors for resident received psychoactive also failed to notify the pressures out of target #15, #29 and #9. Findings included:	aff failed to monitor targ t #8, 24, 22 and 19, who e medications. The fac	ions. O get o cility ent					

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	PROVIDER/SUPPLIER/CLIDENTIFICATION NUMBER		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071		B. WING		07/02/2013
NAME OF PROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE	
GREELEY COUNTY HOSPITAL LTC	CU		D PO BOX 5, KS 6787		
PREFIX (EACH DEFICIENCY MU	EMENT OF DEFICIENCIES UST BE PRECEDED BY FU IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 329 Continued From page 36 Toprol (an anti-hypertens pressure) 25mg (milligram Hypertension (elevated bit Lisinopril (an anti-hyperte for Hypertension) Resident #15's 4/23/13 Qidata set) revealed the resinterview for mental status severe cognitive impairmed. Resident #15's 5/9/13 reviadvised staff to monitor bip parameters for the use of Standing orders dated 4/4 notify the primary physicial systolic blood pressure (to less than 90mmHg (milling greater than 170 mmHg apressure (bottom number 50mmHg or greater than 170 mmHg apressure readings with notify the primary physicial systolic blood pressure (bottom number 50mmHg or greater than 170 mmHg apressure (bottom number 50mmHg or greater than 170 mmHg apressure readings with notify 13/13: 194/87mmHg *2/15/13: 194/87mmHg *4/7/13: 186/89 mmHg *4/7/13: 186/89 mmHg *5/4/13: 189/97 mmHg *5/31/13: 191/190 mmHg *5/31/13: 192/91 mmHg *6/1/13: 185/104 mmHg *6/1/13: 18	sive used to lower blams) every day for blood pressure). ensive) 50mg every day for blood pressure). Ensive) 50mg every day for blood pressure following care plotod pressure for Toprol. (4/13 directed staff to find if a resident 's top number) registermeters of mercury) of and if the diastolic blamber of the readings. (a) It is to provide the following blood one of the readings. (b) Green to the following blood one of the readings. (c) Green to the following blood one of the readings. (c) Green to the following blood one of the readings.	mum brief ated lan ed br lood an	F 329		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		17E071		B. WING		07/0	2/2013
	OVIDER OR SUPPLIER COUNTY HOSPITAL	LTCU	506 THII	RESS, CITY, STA RD PO BOX E, KS 6787	(338		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 329	Continued From page	e 37		F 329			
F 329	An observation on 6/2 (Mountain Standard T ambulated down the I his/her gait remained During an interview of MST, Administrative is resident 's blood presof the parameters set should notify the physical During an interview of MST, Administrative is unaware of the elevated The facility failed to appressure and report ethe physician as directly orders for resident #1 anti-hypertensive medical resident #29's 5/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	25/13 at 4:15p.m. MST ime), Resident #15 nallway independently, steady. In 6/26/13 at 10:14 a.m. staff B revealed that if a sure reading registers by the physician, then sician by phone or fax. In 6/26/13 at 11:20 a.m. staff A revealed he/she red blood pressures. In 6/26/13 at 11:20 a.m. staff A revealed he/she red blood pressures. In 6/26/13 at 11:20 a.m. staff A revealed he/she red blood pressures. In 6/26/13 at 11:20 a.m. staff A revealed he/she red blood pressures. In 6/26/13 at 11:20 a.m. staff A revealed he/she red blood pressures at the facility's standard blood pressures at the facility in the facilit	out staff was d as to ding d an stolic than than e Hg or	F 329			
	following: * 6/7/13: 81/52mmHg * 6/11/13: 85/66 mmH						
	The MAR (medication	administration record)	had				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLE	
		17E071		B. WING		07/	02/2013
	OVIDER OR SUPPLIER 'COUNTY HOSPITAL	LTCU	506 THII	ESS, CITY, STA RD PO BO) E, KS 6787	(338		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 329	documentation that the Prinivil on 6/7/13 and resident's low blood. An observation on 6/2 (Mountain Standard The dining room at the surroundings and fed. During an interview of MST, Administrative sunaware of the low blood B further revealed that not meet the criteria of pressure parameters the physician know by During an interview of MST, Administrative sunaware of the elevated to the surroundings and report physician as directed orders for resident #2 anti-hypertensive medical pressures and report physician as directed orders for resident #2 anti-hypertensive medical made him/herself und cognitive impairment. resident experienced delusions/hallucinatio antipsychotic medical period.	the resident received the 6/11/13, despite the pressure. 25/13 at 8:06 a.m. MST Time), Resident #29 sate table. He/she was ale self without difficulty. In 6/26/13 at 10:24 a.m. staff B revealed he/she cood pressure readings. It if vital signs obtained of the standing order blothe charge staff should by phone or fax. In 6/26/13 at 11:20 a.m. staff A revealed he/she ded blood pressures. In 6/26/13 at 11:20 a.m. staff A revealed he/she ded blood pressures. In 6/26/13 at 11:20 a.m. staff A revealed he/she ded blood pressures. In 6/26/13 at 11:20 a.m. staff A revealed he/she ded blood pressures. In 6/26/13 at 11:20 a.m. staff A revealed he/she ded blood pressures. In 6/26/13 at 11:20 a.m. staff A revealed he/she ded blood pressures. In 6/26/13 at 11:20 a.m. staff A revealed he/she ded blood pressures. In 6/26/13 at 11:20 a.m. staff A revealed he/she ded blood pressures. In 6/26/13 at 11:20 a.m. staff A revealed he/she ded blood pressures to in the facility's standing 9, who received dications.	was Staff did bod let was d the standard standar	F 329			
	Resident #8's 4/27/13 Assessment reported	the resident sometime	s				

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
17E071 B. WING 07/02/201:			17E071		B. WING		07/02	2/2013
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	NAME OF PRO	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE	•	
GREELEY COUNTY HOSPITAL LTCU 506 THIRD PO BOX 338 TRIBUNE, KS 67879	GREELEY	COUNTY HOSPITAL	LTCU					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFLY (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFLY (FACH CORRECTIVE ACTION SHOULD BE	PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF	ULD BE	(X5) COMPLETION DATE
F 329 understands, sometimes made him/herself understood, and experienced short and long term memory problems with severely impaired decision making skills. The MDS reported the resident displayed continuous inattention, disorganized thinking, psychomotor retardation, and altered level of consciousness. The MDS reported the resident experienced a moderate level of depression, delusions, and received antipsychotic medications for 7 of the 7 observation days. Resident #8's 1/25/13 Cognitive Loss CAA (Care Area Assessment) summary reported the resident had a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and due to poor memory recall, the resident often displayed behaviors such as attempting to stand up out of his/her chair that posed the resident as a fall risk. Resident #8's 5/3/13 care plan instructed staff that the resident had a diagnosis of Alzheimer's disease which affected the resident's memory and decision making skills. The care plan reported to monitor for potential side effects and/or adverse consequences related to the FDA (Food and Drug Administration) Black Box Warning for the use of Seroquel as "elderly patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death compared to placebo [a substance containing no medication and prescribed or given to reinforce a patient's expectation to get well Seroquel is not approved for elderly patients with dementia-related psychosis." The care plan informed staff that charge nurses documented behaviors on a behavioral monitoring sheet every shift and to notify the nurse if behaviors arise so the charge nurse can notify the physician.		understands, someting understood, and experimental experiments with decision making skills resident displayed condisorganized thinking and altered level of conference of the resident level of depression, displayed to observation days. Resident #8's 1/25/13 Area Assessment) suresident had a diagnot (progressive mental of by confusion and merimemory recall, the resident had a displayed by confusion and merimemory recall, the resident had a disease which affected and decision making reported to monitor for and/or adverse consection (Food and Drug Admit Warning for the use of patients with demential with antipsychotics and death compared to played to reinforce a patient's Seroquel is not approdementia-related psycinformed staff that challed the product of the prod	nes made him/herself erienced short and long the severely impaired at the severely impaired at the ntinuous inattention, psychomotor retardated to severely impaired at the severely impaired the resident as a fall care plan instructed states at diagnosis of Alzheim and the resident's memory skills. The care plan in potential side effects are plan in severely impaired to the severely impaired to the severely impaired to the severely impaired the severely impaired to severely impaired t	care ase ase ase are are are are are are are are are ar	F 329			

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F 329	Continued From pag	e 40		F 329			
	orally every night for omental disorder characonfusion) with behave 4/4/13 order to increasinght with a new indiction with agitation and any reaction characterized uncertainty and irration reaction characterized uncertainty and irration reaction characterized uncertainty and irration reaction Monthly indicated the resident and "insomnia" (inabinight shifts with intervention Monthly indicated the resident and "insomnia" (inabinight shifts with intervention in the staff identified that to improve/control with then lacked monitorin of those specific behave the specific behave the specific behave the specific displayed no disturbinocasionally moaned reported he/she experise per well at night as different times during	der for Seroquel (an tion) 25 mg (milligrams) dementia (progressive acterized by failing men vioral disturbances and se Seroquel to 50 mg eation of use of dementicity (a mental or emotion by apprehension, anal fear). It's March 2013 and Apprehavioral Monitoring Flow Record" revealed experienced "restless rity to sleep) during multientions of "one to one". The form lacked evide geted behaviors they he the use of Seroquel, and of 6/25/13 at 8:31 a.r. dard Time), resident #8 ag room table and receiner meal.	nory, a every a onal staff ness" ltiple visits ence and ence m. ved				

STATEMENT O		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SI COMPLE	
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				IE, KS 6787			
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F 329	Continued From page	e 41		F 329			
	MST, Administrative Nataff used the behaviors use. Staff B verified that targeted behaviors who be seroquel that they hopresence/absence of #8. On 7/1/13 at 9:05 the record lacked doctor anxiety to support the Seroquel and reported evidence of anxiety of The facility failed to enot receive unnecess failed to adequately mobehaviors while the record lacked doctor and the facility failed to enot receive unnecess failed to adequately mobehaviors while the resident #22's 4/3 Data Set) Assessment understands others and the resident received antidepressant medic days. Resident #22's 5/1/13 CAA (Care Area Asset the resident received medication) and Zolod medication) due to past becoming agitated with the resident's routine displayed such behaviors.	those behaviors for rest a.m. MST, Staff B vericumentation of agitation is start of or the increase of the clinical record lact agitation. Insure that resident #8 cary medications as staff and his/her spotth and made him/herself erately impaired cognitic resident displayed no osychosis, or behaviors antipsychotic and ation 7 of the 7 observations.	d that y on fy ed sident iffied a and e of ked did ff uel. imum on. c, and ation e orted notic dent use if urned				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE	
		17E071		B. WING	 	07/0	02/2013
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F 329	Resident #22's 6/3/13 that the resident enjoins/her spouse but not an antidepressant me confusion with a histoplan instructed staff this/her depression or charge nurse so he/sphysician. The care side effects and/or acrelated to the FDA (FAdministration) Black Seroquel and Zoloft, documented behavior charge nurse notified that arose. Resident #22's 5/13/included renewed ord (milligrams) orally ev (abnormal emotional exaggerated feelings and emptiness) with Seroquel 25 mg orall indication of use as "general term referring and loss of reality) with Review of resident #2" Depression/Behavior Monthly Flow Record displayed no distress month. The form lack hoped to control with Zoloft and lacked eviof those specific behavior MST (Mountain Stantantantantantantantantantantantantant	3 care plan instructed singled spending time with out group activities, received action, and experience or of agitation. The case of watch for worsening of agitation and notify the she could notify the plan included the possible diverse consequences food and Drug as Box Warning for the use the charge nurse are every shift, and the latten physician's orders ders for Zoloft 50 mg ery day for depression state characterized by a of sadness, worthless a start date of 4/17/12 at y every day with an unspecified psychosis go to a condition of the match a start date of 9/5/12 at y every day with an unspecified psychosis go to a condition of the match a start date of 9/5/12 at y every day with an unspecified psychosis go to a condition of the match a start date of 9/5/12 at y every day with an unspecified psychosis. The use of Seroquel and dence of presence/abset the use of Seroquel and dence of presence/abset at the start date of Seroquel and dence of presence/abset at the start date of Seroquel and dence of presence/abset at the start date of Seroquel and dence of presence/abset at the start date of Seroquel and dence of presence/abset at the start date of Seroquel and dence of presence/abset at the start date of Seroquel and dence of presence/abset at the start date of Seroquel and dence of presence/abset at the start date of Seroquel and dence of presence/abset at the start date of Seroquel and dence of presence/abset at the start date of Seroquel and dence of presence/abset at the start date of Seroquel and dence of presence/abset at the start date of Seroquel and dence of presence/abset at the start date of Seroquel and dence of presence/abset at the start date of Seroquel and dence of presence/abset at the start date of Seroquel and dence of seroquel and	ved ced re of e ble se of erns ness and (a nind ion e they d ence .m. 2	F 329			

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F 329	with a cane as he/she spouse. During an interview o Direct Care Staff H redisplayed no distressiover the past year. During an interview o MST, Administrative Noresident became agits spouse and staff in the received Zoloft and Society resident no longer discontinuous Staff B reported a lact symptoms of depressionand reported that staff document any distressident may distress medication use. Staff record lacked evidence that the targeted behavior Zoloft and Seroquel the targeted behaviors. The facility failed to e receive unnecessary to adequately monitor while he/she received. Resident #19's 6/12 Status MDS (Minimur reported the resident others and sometimes understood with seve MDS reported during	e conversed with his/he in 6/26/13 at 7:56 a.m. Inported the resident ing behaviors currently in 6/26/13 at 11:01 a.m. Nursing Staff B reported ated and upset with his. is past before he/she eroquel and currently the played those behaviors is of awareness of any ion the resident display if use the behavior form sing behaviors not related the clinical that staff monitored it is for resident #22's use that staff hoped to contribe of those specific Insure resident #22 did medications as staff fair for targeted behaviors at Zoloft and Seroquel. In 2/13 Significant Change in Data Set) Assessment is made him/herself irely impaired cognition. In the 7 observation days acute hospital on 5/2/1 ity on 5/30/13	MST, and d the /her ne s. red to ted to for e of ol or not led e of nt s . The	F 329			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		17E071		B. WING		07/02	2/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
GREELEY				D PO BOX E, KS 6787			
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F 329	* experienced delusion * displayed physical le 6 days * displayed verbal be * rejected cares from * noted an acute wor clinical condition * received antipsycho medications 7 days Resident #19's 6/13/1 (Care Area Assessme resident transferred to psychiatric hospital an acted agitated and ex decline with his/her an Resident #19's 6/13/1 Drug Use CAA summ received Wellbutrin an antidepressant medic (an antipsychotic medication with esident "is easily exc during the observation Resident #19's 3/4/13 that the resident had anxious if told too far appointments or even onto his/her medication out the medications if care plan instructed s anxiety and behaviors can then notify the ph instructed staff to mor and/or adverse conse (Food and Drug Admi Warnings for antidepr	chaviors 1 to 3 days staff 4 to 6 days sening of the resident's office and antidepressant of a Cognitive Loss CAA ent) summary reported of an acute geriatric and since his/her return of the perienced a functional ctivities of daily living. 3 Mood and Psychotrolaries reported the resident Celexa (both ations) along with Sero dication) and noted the citable and cries very early perienced of upcoming a set routine and becard in advanced of upcoming and tended to either ons in his/her cheek and not monitored closely, taff to monitor for worses and notify the nurse whysician. The care planning into the proposible side evaluation of the proposible side evaluation of the care planning for possible side evaluation. Black Box ressants and the use of the charge nurse docume	the had pic dent quel asily" aff me ng hold d spit The ening /ho ffects FDA	F 329			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUR COMPLETE	
		17E071		B. WING		07/02	2/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
GREELEY	COUNTY HOSPITAL	LTCU		RD PO BOX E, KS 6787			
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F 329	physician if concerns Resident #19's 5/30/1 orders included new of (extended release) 18 every day for depress state characterized by sadness, worthlessne Celexa 20 mg orally of The readmission order for Seroquel XR (exterevery day for bipolar of illness that causes persevere high and low roriginal 6/11/12 order Review of resident #1 Monitoring Intervention revealed: * April 2013: the residistressing behaviors	arose. 13 readmission physicial orders for Wellbutrin XL 50 mg (milligrams) orall sion (abnormal emotion y exaggerated feelings as and emptiness) and every day for depression ers included a 5/30/13 cended release) 300 mg disorder (a major mentatople to have episodes moods) which increased of 100 mg daily. 19's "Depression/Behavon Monthly Flow Recordident displayed no throughout the month ansferred to an acute nit on 5/2/13	of d of d order orally al of d the	F 329			
	distressing behaviors documented the resic facility) between 5/3/1 resident displayed no 5/31/13 * June 2013: staff do displayed occasional behaviors with "one of interventions with no Review of resident #1 evidence that staff model behaviors while the result. Celexa, and Sero	5/1/13 and 5/2/13, state lent as "OOF" (out of the last and 5/30/13, and the distressing behaviors of the last and 5/30/13, and the distressing behaviors of the last and hyper" on one" and "redirection improvement. 9's clinical record lacked positioned for targeted esident received Wellburguel for behaviors they the presence/absence	ne e oon "" ed utrin				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X	(1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE	
	17E071		B. WING		07/0	02/2013
NAME OF PROVIDER OR SUPPLIER GREELEY COUNTY HOSPITAL L	тси	506 THII	RESS, CITY, STA RD PO BOX IE, KS 6787	(338		
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During an observation of MST (Mountain Standard calmly cooperated with Licensed Nursing Staff assistance for toilet used During an interview on the Direct Care Staff I report out in the facility's commedications, and attem cares prior to transferring psychiatric hospital on the resident stopped walking rarely spoke after he/sh on 5/30/13. Staff I report that the resident's medications again and scares. During an interview on the MST, Administrative Nuresident frequently resist his/her medications prict acute geriatric psychiatric his/her return to the facing awareness that staff faild distressing behaviors of monitoring form. Staff Ethe behavior form to do behaviors not related to verified the clinical reconstaff monitored for the tresident #19's use of W Seroquel that staff hope presence/absence of the The facility failed to enserve unnecessary medications as a service with the service of the tresident facility failed to enserve unnecessary medications are serviced to the service unnecessary medication of the service unnecessary medication	on 6/25/13 at 12:33 p. ard Time), resident #19 Direct Care Staff D a C while he/she receive. 6/25/13 at 9:33 a.m. Norted that resident yellow mon areas, spit out his apted to hit staff duringing to the acute geriatr 5/2/13. Staff I reported go due to weakness and returned to the facility of the to the faction changed currestarted to spit out still occasionally resisted cares and spit out or to transferring to the critic hospital and after cility, and lacked illed to document these on the behavioral B reported that staff under the staff of the s	9 Ind wed Ind wed Ind wed Ind wed Ind Ind Ind Ind Ind Ind Ind Ind Ind In	F 329			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUF	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE		
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F 329	to adequately monitor while he/she received Seroquel. - Resident #24's 4/30 Data Set) Assessmer understands others a understood with mode The MDS reported the behaviors, no delusion received antipsychotic medications for 7 of the Resident #24's 5/1/13 Psychotropic Drug Us Assessment) summai received Zyprexa (an and Zoloft (an antidepthe resident had rand with "very agitated beto the facility that now controlled, and the beto the physician attemptimedication dosages. Resident #24's 6/3/13 monitor for the potent adverse consequence Drug Administration) the resident received care plan instructed sof his/her overall consuicide, the charge nuon a behavioral monitor.	for targeted behaviors Wellbutrin, Celexa, and Wellbutrin Merself erately impaired cognitive resident displayed nons or hallucinations, and and antidepressant me 7 observation days. Cognitive Loss and Se CAA (Care Area ries reported the reside antipsychotic medications and provided antipsychotic medications who well and well an	mum on. on. od ent on) nat ion sion en taff to d nile ne ening viors and	F 329			
	included renewed ord	ers for Zyprexa (an					

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F 329	antipsychotic medical orally twice a day for mental disorder characonfusion) with behaviorally twice a day for mental disorder characonfusion) with behavioral start date of 7/2/12 armedication) 50 mg ordepression (abnormath characterized by exagusadness, worthlessnesstart date of 5/27/12. Review of resident #2 "Depression/Behavioral Monthly Flow Record experienced one episshift with an intervent no change in outcome of the target behavioral the resident received lacked monitoring of the target behavioral three resident received lacked monitoring of the target behavioral three resident received lacked monitoring of the target behavioral three resident received lacked monitoring of the target behavioral three resident received lacked monitoring of the target behavioral three resident received lacked monitoring of the target behavioral three resident received lacked monitoring of the lacked monitoring an interview of Direct Care Staff H repreferred a set routing yelled out paranoia-ty appointments such as later than expected. During an interview of MST, Administrative Monitoring but lacked monitoring but lacked monitoring but lacked monitoring of the lac	tion) 2.5 mg (milligrams dementia (progressive dementia) (progressive deterized by failing menorioral disturbances with and Zoloft (an antidepressally every night for I emotional state gegerated feelings of ess and emptiness) with the Advis June 2013 ral Monitoring Intervent revealed the resident gode of paranoia on the ion of "one to one" visite. The form lacked menor they hoped to control of Advis Zyprexa and Zoloft, and those specific behaviors on on 6/25/13 at 10:31 at dard Time), resident #24 and became upset are perstatements after design of 6/26/13 at 11:01 a.m. Nursing Staff B reported resident design of any staff B reported resident safter design of the encountered change sked awareness of any staff B reported resident safter design of the encountered change sked awareness of any staff B reported resident safter design of the encountered change sked awareness of any staff B reported resident safter design of the encountered change sked awareness of any staff B reported residents and the encountered change sked awareness of any staff B reported residents and the encountered change sked awareness of any staff B reported residents and the encountered change sked awareness of any staff B reported residents and the encountered change sked awareness of any staff B reported residents and the encountered change sked awareness of any staff B reported residents and the encountered change sked awareness of any staff B reported residents and the encountered change sked awareness of any staff B reported residents and the encountered change sked awareness of any staff B reported residents and the encountered change sked awareness of any staff B reported residents and the encountered change sked awareness of any staff B reported residents and the encountered change sked awareness of any staff B reported residents and the encountered change sked awareness of any staff B reported residents and the encountered change sked awareness of any staff B reported residents and the encountered change sked awareness of any staff	nory, a ssant ion night and ntion while d sm. 4 sat with MST, ad layed one d the d es in	F 329			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1, ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 329	behavior form to docube haviors not related verified the clinical restaff monitored for the resident #24's use of hoped to control or the those specific behavior. The facility failed to e receive unnecessary to adequately monitor while he/she received. Resident #17's 5/13 included a diagnosis of blood pressure) and confilligrams) 1 1/2 table 60 mg. daily (both and used to lower the blood Resident #17's 3/23/11 data set) assessment BIMS (brief interview 10 which indicated meand required limited a activities of daily living diuretic therapy during period. The resident's 9/20/12 assessment) summar revealed the resident assistance with a wall Resident #17's 4/2/13 interventions and box use of Propanolol and	to medication use. State ord lacked evidence the targeted behaviors for Zyprexa and Zoloft that e presence/absence of ors. Insure resident #24 did medications as staff fair for targeted behaviors and Zoloft. If a physician order shoof hypertension (elevator for Propanolol 10 lets twice a day and Lati-hypertensive medicated pressure). If a quarterly MDS (mining revealed the resident lating for mental status) score orderately impaired cognissistance of 1 person for the resident received and the same of t	nat t staff not led eet ed 0 mg six ions mum had a e of nition for d ment iving	F 329			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SUF COMPLET	
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F 329	notify the primary phy blood pressure (top n 90 mmHg (millimeters 170 mmHg and if the (bottom number) regis or greater than 100 m Review of resident #1 revealed a blood pres and 189/98 on 4/26/1 record lacked any do notified the physician pressures. During an observation resident #17 ambulate gait with assistance of gait belt and a walker. An interview on 6/25/licensed nurse B confiblood pressure paramorders for physician in signs. He/she stated elevated blood pressus should be documented Licensed nurse B conclinical record lacked notification of the resi pressures on 4/22/13	rsician if a resident's sylumber) registered less of mercury) or greater diastolic blood pressurestered less than 50 mm mHg. 17's vital signs record asure of 182/80 on 4/22 a. Review of the clinical cumentation that staff of the elevated blood on on 6/25/13 at 5:30 p.r. ed in the hall with a steaf direct care staff P using the companion of abnormal when a resident had an ure, physician notification of dent's elevated blood and 4/26/13. dequately monitor resides according to the the standing orders. d anti-hypertensive	than r than e nHg 2/13 al m., ady ng a the nding vital n on	F 329			
	IMMUNIZATIONS	A AND PNEUMOCOC		F 334			
	The facility must deve	elop policies and proced	dures				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		1 ' '	E CONSTRUCTION	(X3) DATE S COMPL	
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F 334 Continued From pag	ge 51		F 334			
that ensure that (i) Before offering the each resident, or the representative receive benefits and potential immunization; (ii) Each resident is contraindicated or the immunized during the contraindicated or the immunized during the (iii) The resident or the representative has the immunization; and (iv) The resident's medocumentation that in following: (A) That the resident representative was put the benefits and pote immunization; and (B) That the resider influenza immunization influenza immunization contraindications or influenza immunization. The facility must deventhat ensure that (i) Before offering the immunization, each in legal representative the benefits and pote immunization; (ii) Each resident is continuing immunization, unless medically contraindical already been immunical influence immunication.) The resident or t	e influenza immunization resident's legal ves education regarding al side effects of the offered an influenza er 1 through March 31 immunization is medica e resident has already be is time period; the resident's legal the opportunity to refuse edical record includes andicates, at a minimum, and or resident's legal provided education regal ential side effects of influent either received the on or did not receive the on due to medical refusal. Telop policies and proceive pneumococcal resident, or the resident receives education regal ential side effects of the offered a pneumococcal state immunization is cated or the resident has ized;	the Illy been the dures dures ranging	F 334			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE	
		17E071		B. WING		07/0)2/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
GREELEY	COUNTY HOSPITAL	LTCU		RD PO BO) IE, KS 6787			
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F 334	(iv) The resident's medocumentation that in following: (A) That the residen representative was provided the benefits and potent pneumococcal immur (B) That the residen pneumococcal immur the pneumococcal immur the pneumococcal immur contraindication or reconstruction or reconstruc	edical record includes adicated, at a minimum, at or resident's legal covided education regardial side effects of nization; and at either received the nization or did not receimunization due to med fusal. based on an assessment medicalion, a second nization may be given a set pneumococcal medically contraindicat sident's legal represents	rding ve ical ent ifter 5	F 334			
	The facility reported a 5 residents sampled for a 5 residents sampled for a 5 residents sampled for a 6 resident sampled for a 6 resident sampled for their representation of the immunization a 6 prior to administration vaccination and failed education in 3 of the 6 record. (Residents #2 Findings included:	not met as evidenced by census of 26 residents for review of immunization of record review, the fatto of the 5 sampled residentives received educates and potential side effected the opportunity to real of the 2012-2013 influed to document staff provides as provided the composition of the 2012-2013 influed to document staff provided to the composition of the 2012-2013 influed to the composition of the 2012-2013 influed to document staff provided the composition of the 2012-2013 influed to the composition of the compositio	s with ions. acility lents ion ects efuse enza vided inical				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E071		B. WING		07/0	2/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE	•	
GREELEY	COUNTY HOSPITAL	LTCU		RD PO BOX E, KS 6787			
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F 334	representative received benefits and potential 2012-2013 influenzation these residents' clinic received the influenzations/her left upper arm. Review of resident #2 the resident received benefits and potential 2012-2013 influenzation resident #20's clinical resident received the 10/18/12 in the left upper action at the vaccine). During an interview of (Mountain Standard Toursing Staff B reported education to residents the 2012-2013 influenzation for multiple Staff B reported he/st form with indication that to residents #22, 20, approximately a month the vaccine and did not from #22, #4, and #24 verified the clinical residents that staff provided education to residents the vaccine and did not from #22, #4, and #24 verified the clinical residents that staff provided education to residents that staff provided education to residents residents #21, 20, approximately a month the vaccine and did not from #22, #4, and #24 verified the clinical residents that staff provided education to residents provided education to residents received benefits and potential 2012-2013 influenzation at the vaccine of the residents residents residents residents residents received benefits and residents	ed education regarding side effects for the immunization. Each of al record revealed they a vaccine on 10/18/12 in 20's clinical record revealed treceducation regarding the side effects of the immunization on 11/12/al record revealed the influenza vaccine on oper arm (25 days prior and the opportunity to refer the first out of the proper arm (25 days prior and the opportunity to refer the first out of the first out of the provided to proper arm (25 days prior and the opportunity to refer the first out of the fi	aled e f12. to efuse MST vide I to /12. t ation ives tered k aff B ation	F 334	DEFICIENCY)		
	who wishes to receive	reviewed on 6/24/13, like sure that each resid					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			E CONSTRUCTION	(X3) DATE S COMPL	
		17E071		B. WING		07	/02/2013
	STREET ADDRESS, CITY, STATE, ZIP CODE SELEY COUNTY HOSPITAL LTCU 506 THIRD PO BOX 338 TRIBUNE, KS 67879						
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY F OR LSC IDENTIFYING INFORMA	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 334	vaccine or immuniz and that it is docum The facility failed to #4, and #22 and/or education prior to a influenza vaccine to refuse and failed to	age 54 ation prior to administration prior to administration prior to administration of the service administration of the 2012 provide an opportunity to document that staff provints #22, #4, and #24's climation prior to the service administration of the service and serv	nart". 20, sived 2-2013 to vided	F 334			
F 371 SS=F	The facility must - (1) Procure food fro considered satisfac authorities; and	SERVE - SANITARY om sources approved or ctory by Federal, State or distribute and serve food		F 371			
	The facility had a ce	is not met as evidenced I ensus of 26 residents wit room that served all the	-				
		ion, interview, and record ailed to prepare and trans conditions.					
	Findings included:						
	the following: Dietar hands and put on c making the pureed	-24-13 at 10:00 a.m. revery staff K washed his/her lean gloves in preparatio diets. He/she then tore a pork cutlets and put those	n of part 3				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION	(X3) DATE SU COMPLE	
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	COUNTY HOSPITAL	LTCII		RD PO BOX			
OKLLLL	COOKITTICOTTIAL	2100		IE, KS 6787			
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F 371	Continued From page	e 55		F 371			
	pieces into a blender.	. He/she added broth to	the				
		nder lid on. Dietary staff					
		ender with the same glo					
	_	oth and meat mixture, d	- 1				
		ore pieces of pork cutlet ne pureed mixture. He					
	did not change his/he	•	/SITE				
	_	reed meat after touching	a the				
	blender or the contain						
	During an interview o	n 6-26-13 at 1:15 p.m.,					
		ated he/she expected s					
	change gloves after h	nandling kitchen equipm	nent				
	before touching foods	S.					
	Review of the facility	's Use of Plastic Glove	s				
	Policy dated 3-22-12	states, " Anytime a					
		e is touched, the gloves					
		food preparations, as o					
		oved soil and contamina	ition				
	and to prevent cross changing tasks. "	contamination when					
	onanging taono.						
	The facility failed to p conditions.	repare food under sani	tary				
	An aban attac	0.05.40.54.44.55					
		6-25-13 at 11:55 a.m.	#21'6				
		f I transported resident oom down a resident ha					
	-	ble. The plate on the ro	-				
		wing: ground meat, bro					
	•	s, and iced tea in a glas					
		e glass remained uncov					
		down the hallway to the	•				
	resident's room.						
	Another observation of	on 6-26-13 at 12:00 p.n	ղ.				
		f D transported room tra					
	for residents #27, #29		, -				
		ain on an over the bed					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C			LE CONSTRUCTION	(X3) DATE SI COMPLE	
		17E071		B. WING		07/	02/2013
	OVIDER OR SUPPLIER COUNTY HOSPITAL	LTCU	506 TH	RESS, CITY, STA IRD PO BO) NE, KS 6787	K 338		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 371	chicken, baked potatovegetable salad. The tea with their lunches glasses remained und transportation down the rooms. During an interview of dietary staff L stated by the cover all plates of figlasses with plastic of for transport to the result of the re	ontained ground or bak oes, green beans, and a residents also received a Again all the plates are covered during the the hallway to the resident of 6-26-13 at 1:15 pm, he/she expected dietary food with plate covers and the trays kept in the cosidents ' rooms. In 6-26-13 at 1:30 pm, A stated he/she expected taff to cover all food and or ting them to the resident of the cover all food and or ting them to the resident of the cover all food and or ting them to the resident of the cover all food and or ting them to the resident of the cover all food and or ting them to the resident of the cover all food and or ting them to the resident of the cover all food and or ting them to the resident of the cover all food and or ting them to the resident of the cover and the c	a diced and diced and dicents ' y staff and arts diced dicents ' coolicy off.	F 371			
	conditions. 483.60(a),(b) PHARM ACCURATE PROCE		illary	F 425			
	drugs and biologicals them under an agree §483.75(h) of this par	rt. The facility may perr I to administer drugs if S under the general	ain mit				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SUF	
		17E071		B. WING		07/02	2/2013
	OVIDER OR SUPPLIER COUNTY HOSPITAL	LTCU		ESS, CITY, STA RD PO BOX E, KS 6787	(338		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 425	Continued From page	e 57		F 425			
	(including procedures acquiring, receiving, o	rugs and biologicals) to	ite				
	The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.						
	This Requirement is not met as evidenced by: The facility reported a census of 26 residents with 10 residents reviewed for unnecessary medications.						
	Based on observation, interview, and record review, the facility failed to ensure 1 of the 10 sampled residents received all drugs and biologicals to meet the needs of that resident as staff failed to ensure the resident received a Fentanyl patch as ordered by the physician. (Resident #24)		0				
	Findings included:						
	Data Set) Assessmer understands others a understood with mode The MDS reported the	0/13 Annual MDS (Minin at reported the resident and made him/herself erate impaired cognition e resident reported he/se during the observation	n.				
	Resident #24's 5/1/13 Area Assessment) su	Cognitive Loss CAA (mmary reported the	Care				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		A. BUILDING	E CONSTRUCTION	(X3) DATE SUR COMPLETE	
		17E071		B. WING		07/02	2/2013
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE	•	
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F 425	resident stated his/he current treatment. Resident #24's 6/3/13 note the resident recipain due to pain from on the resident's skin instructed that the paragraph on the scheduled day to get the best coverage to get the best coverage (a pain medical hours for chronic pain reproductive organ). Review of resident #2 Administration Recordinitials for the Fentant 6/16/13 and noted or available" on both data failed to administer the 6/10/13 and 6/19/13. patch on 6/12/13, state Fentanyl patch for 7 pain relief. Between administered no PRN and review of the nur documentation related Lexi-Comp's Drug Referiatric Dosage Haid 675 through 684, insite transdermal patches patch every 72 hours symptoms are possible.	as care plan instructed served a medicated patch of cancer that needed to at all times. The care atch needed to be changed to be changed age to control his/her patch of the cancer of a served and at the scheduled age to control his/her patch of the cancer of a served at the cancer of the served at the served at the cancer of the served at the served	taff to h for stay plan ged I time ain. anyl 2 ation rcled I not raff een 10/13 ne t of taff ons . ages e the al	F 425			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1, ,	LE CONSTRUCTION	(X3) DATE SUI COMPLET	
		17E071		B. WING		07/0	2/2013
GREELEY COUNTY HOSPITAL LTCU 5			506 THII	RESS, CITY, STA RD PO BOX E, KS 6787	(338		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 425	During an observation MST (Mountain Standambulated independent showed no outward signification, moaning, moaning an interview of MST, Administrative of a lack of awareness to the Fentanyl patch or B reported that reside denying pain when as his/her family to compain, so when the resident during the MDS intervited information to know it controlled. Staff B rephysician ordered the basis, the pharmacy sadvance as soon as serefill the supply to the the facility failed to enhis/her Fentanyl patch physician. During an interview of Consultant F reported pharmacy did not refipatch by 6/16/13 due the physician. Consultants of the new written until 6/18/13 afilled and delivered the filled and delivered the moaning staff held resident and delivered the filled and delivered t	n on 6/25/13 at 11:39 a dard Time), resident #2-ently in the hallway and signs of pain such as or guarding body parts. In 6/24/13 at 11:31 a.m. enied having pain currently at 12:41 a.m. Nursing Staff B reported that staff failed to admin 6/16/13 and 6/19/13. Ent #24 had a history of sked by staff then called plain that he/she felt sericident denied pain issue view he/she relied on fat the resident's pain felt ported that since the expatch on a scheduled sent the medication in staff reported the need to pharmacy. Staff B vernsure the resident receith as ordered by the	antity or antity	F 425			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
17E071		17E071		B. WING		07/02/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
GREELEY	COUNTY HOSPITAL	LTCU	506 THIR	D PO BOX	(338		
			TRIBUNE	, KS 6787	9		
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F 425	Continued From page	e 60		F 425			
	received all drugs and biologicals as staff failed to administer his/her physician ordered Fentanyl patches on 6/13/13 and 6/16/13.						
	483.60(c) DRUG REC IRREGULAR, ACT O	GIMEN REVIEW, REPO N	ORT	F 428			
	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.						
	The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.						
	This Requirement is not met as evidenced by: The facility reported a census of 26 with 10 residents reviewed for unnecessary medications. Based on observation, interview and record review, the facility failed to ensure that the Consultant Pharmacist identified drug irregularities for 7 of 10 residents sampled for unnecessary medications when staff failed to monitor target behaviors for resident #8, 24, 22 and 19, who received psychoactive medications and also failed to adequately monitor blood pressures for residents #15, #29, and #9, who received anti-hypertensive medications. Findings included: - Resident #15 5/1/13 medication order sheet revealed orders for:		or or 22 ons				
	pressure) 25mg (millig Hypertension (elevate		IOOG				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED	` '	
17E071 B. WING 07/02/2013	3	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
GREELEY COUNTY HOSPITAL LTCU 506 THIRD PO BOX 338 TRIBUNE, KS 67879		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) IPLETION DATE	
Lisinopril (an anti-hypertensive) 50mg every day for Hypertension Resident #15's 4/23/13 Quarterly MDS (minimum data set) revealed the resident had a BIMS (brief interview for mental status) score which indicated severe cognitive impairment. Resident #15's 5/9/13 revised nursing care plan advised staff to monitor blood pressure parameters for the use of Toprol. Standing orders dated 4/4/13 directed staff to notify the primary physician if a resident's systolic blood pressure (top number) registered less than 90mmHg (millimeters of mercury) or greater than 170 mmHg and if the diastolic blood pressure (bottom number) registered less than 50mmHg or greater than 100 mmHg. The clinical record revealed the following blood pressure readings with none of the readings. * 2/15/13: 194/87mmHg * 2/15/13: 194/87mmHg * 4/7/13: 186/89 mmHg * 4/30/13: 183/186 mmHg * 5/34/13: 183/186 mmHg * 5/34/13: 185/104 mmHg Review of the clinical record revealed a lack of documentation of physician notification of the elevated blood pressures, above the parameters established in the facility standing orders. Resident #15's monthly medication reviews dated 6/27/12, 7/18/12, 8/16/12, 9/26/12,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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GREELEY COUNTY HOSPITAL LTCU 506 TH				ESS, CITY, STA RD PO BO) E, KS 6787	(338	·		
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F 428	10/30/12, 11/30/12, 1 4/30/13 and 5/31/13 r blood pressure eleval director of nursing. An observation on 6/2 (Mountain Standard I ambulated down the l his/her gait remained During an interview o MST, Administrative s resident 's blood pres of the parameters set should notify the phys During an interview o Consultant Pharmacis at the blood pressure pressure monitoring s trends, but was unaw pressures or lack of p The facility failed to e pharmacist identified resident #15 's eleva receiving anti-hyperte - Resident #29's 5/1/ order for Prinivil (an a (milligram) every day Standing orders date notify the primary phy systolic blood pressur less than 90mmHg (n greater than 170 mml	2/28/12, 1/31/13, 3/30/revealed no notification tions to the physician of 25/13 at 4:15p.m.MST ime), Resident #15 hallway independently, steady. In 6/26/13 at 10:14 a.m. staff B revealed that if a sure reading registers by the physician, then sician by phone or fax. In 6/26/13 at 2:32 p.m. If the first physician is at 2:32 p.m. If the first physician and the big system and looked for are of the elevated blook physician notifications. Insure the consultant drug irregularities related blood pressures when sive medications. In 3 order sheet revealed anti-hypertensive) 10mg for Hypertension. In 4/4/13 directed staff to receive the fillimeters of mercury) of the gand if the diastolic baber) registered less the last of the progression of the diastolic baber) registered less the last of the physician registered less the physician	of f f a out staff MST, bked lood od ed to nile d an f o red or	F 428				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED	(X3) DATE SURVEY COMPLETED	
17E071 B. WING 07/02/201	07/02/2013	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
GREELEY COUNTY HOSPITAL LTCU 506 THIRD PO BOX 338 TRIBUNE, KS 67879		
	(X5) COMPLETION DATE	
Resident #29 's monthly medication review dated 4/30/13 and 6/11/13 revealed no notification of resident 's low blood pressure to the physician or director of nursing. Resident #29 's vital sign record revealed the following: 6/7/13: 81/52mmHg 6/11/13: 88/66 mmHg The MAR (medication administration record) had documentation that the resident received the Prinivil on 6/7/13 and 6/11/13, despite the resident 's low blood pressure. An observation on 6/25/13 at 8:06 a.m. MST (Mountain Standard Time), Resident #29 sat in the dining room at the table. He/she was alert to surroundings and fed self without difficulty. During an interview on 6/26/13 at 10:24 a.m. MST, Administrative staff B revealed he/she was unaware of the low blood pressure readings. Staff B further revealed that if vital signs obtained did not meet the criteria of the standing order blood pressure parameters the charge staff should let the physician know by phone or fax. During an interview on 6/26/13 at 2:32 p.m. MST, Consultant Pharmacist F revealed he/she look3e at the blood pressure medications and the blood pressure or lack of physician notifications. The facility failed to ensure the consultant pharmacist identified drug irregularities related to resident #15' s low blood pressures while receiving anti-hypertensive medications.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBE			1 ' '	LE CONSTRUCTION	(X3) DATE SU COMPLET		
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F 428	F 428 Continued From page 64 - Resident #8's 1/25/13 Annual MDS (Minimum Data Set) Assessment reported the resident			F 428			
	sometimes understa made him/herself un cognitive impairmen resident experienced delusions/hallucinati	nds others and sometime derstood with severe to the MDS reported the domain and including the domain and received no distressing the observations during the observations during the observations.	e rs, no				
	Resident #8's 4/27/13 Quarterly MDS Assessment reported the resident sometimes understands, sometimes made him/herself understood, and experienced short and long term memory problems with severely impaired decision making skills. The MDS reported the resident displayed continuous inattention, disorganized thinking, psychomotor retardation, and altered level of consciousness. The MDS reported the resident experienced a moderate level of depression, delusions, and received antipsychotic medications for 7 of the 7 observation days.						
	Area Assessment) s resident had a diagn (progressive mental by confusion and memory recall, the rebehaviors such as a	3 Cognitive Loss CAA (ummary reported the losis of Alzheimer's dise deterioration characterizemory failure) and due to esident often displayed ttempting to stand up oused the resident as a fall	ase zed o poor				
	that the resident had disease which affect and decision making reported to monitor f	care plan instructed stated a diagnosis of Alzheimoned the resident's memoners skills. The care plan for potential side effects requences related to the	er's ry				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			A. BUILDING		(X3) DATE SURVEY COMPLETED		
	17E071			B. WING		07.	/02/2013
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	TE, ZIP CODE		
GREELEY	COUNTY HOSPITA	AL LTCU		RD PO BOX E, KS 67879			
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F 428	(Food and Drug Ad Warning for the use patients with demer with antipsychotics death compared to containing no media to reinforce a patient Seroquel is not app dementia-related prinformed staff that to behaviors on a	ministration) Black Box of Seroquel as "elderly ntia-related psychosis treare at an increased risk of placebo [a substance cation and prescribed or nt's expectation to get we proved for elderly patients sychosis." The care plan charge nurses documente avioral monitoring sheet are nurse if behaviors arise an notify the physician. #8's physician's orders order for Seroquel (an cation) 25 mg (milligrams or dementia (progressive aracterized by failing mentavioral disturbances and ease Seroquel to 50 mg of dication of use of dementance of dementa	given ell] s with ed every e so) nory, a every ia ional ril staff ness" ltiple ' visits ence noped and ence	F 428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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GREELEY COUNTY HOSPITAL LTCU 506 T			506 THII	RESS, CITY, STA RD PO BOX E, KS 6787	(338			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 428	5/27/13, the pharmack document he/she revirecord for targeted be the resident received During an observation MST (Mountain Stand calmly sat at the dining assistance to eat his/li> During an interview of Consultant F reported awareness that staff is such as resident #8, for monitoring while taking the facility failed to econsultant reported in physician and director to monitor resident #8 he/she received Serounderstands others a understood with mode The MDS reported the signs of depression, puther resident received antidepressant medical days. Resident #22's 5/1/13 CAA (Care Area Asset the resident received medication) and Zolomedication) due to passed becoming agitated withe resident's routine.	y consultant failed to lewed the resident's cline thavioral monitoring who Seroquel. In on 6/25/13 at 8:31 a.r. dard Time), resident #8 ag room table and receipher meal. In 6/26/13 at 2:21 p.m. In that he/she lacked needed to monitor resider targeted behavioral ag Seroquel. In sure that the pharmack regularities to the attent of nursing that staff facts targeted behaviors who was a compared to the resident and made him/herself that the pharmack regularities to the attent of nursing that staff facts targeted behaviors who was a compared to the resident of the pharmack of the resident displayed not be provided that the pharmack of the pharmack o	ile in. ved MST, lents, lents, lents imum on. , and ation e orted notic lent use if	F 428				

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 17E071 B. WING 07/02/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **GREELEY COUNTY HOSPITAL LTCU 506 THIRD PO BOX 338** TRIBUNE, KS 67879 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 428 F 428 Continued From page 67 if the physician reduced the medication dosage. Resident #22's 6/3/13 care plan instructed staff that the resident enjoyed spending time with his/her spouse but not group activities, received an antidepressant medication, and experienced confusion with a history of agitation. The care plan instructed staff to watch for worsening of his/her depression or agitation and notify the charge nurse so he/she could notify the physician. The care plan included the possible side effects and/or adverse consequences related to the FDA (Food and Drug Administration) Black Box Warning for the use of Seroquel and Zoloft, the charge nurse documented behaviors every shift, and the charge nurse notified the physicians of concerns that arose. Resident #22's 5/13/13 physician's orders included renewed orders for Zoloft 50 mg (milligrams) orally every day for depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) with a start date of 4/17/12 and Seroquel 25 mg orally every day with an indication of use as "unspecified psychosis" (a general term referring to a condition of the mind and loss of reality) with a start date of 9/5/12. Review of resident #22's June 2013 "Depression/Behavioral Monitoring Intervention Monthly Flow Record" revealed the resident displayed no distressing behaviors during the month. The form lacked targeting behaviors they hoped to control with the use of Seroquel and Zoloft and lacked evidence of presence/absence of those specific behaviors. Review of resident #22's pharmacist consultant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		07/0	07/02/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•		
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(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 428	Continued From page	e 68		F 428				
	monthly medication review between 6/27/12 and 5/27/13, the pharmacist consultant failed to document that he/she reviewed the resident's clinical record for targeted behavioral monitoring while the resident received Seroquel and Zoloft.							
	During an observation on 6/25/13 at 11:20 a.m. MST (Mountain Standard Time), resident #22 calmly ambulated independently in the hallway with a cane as he/she conversed with his/her spouse.							
	During an interview on 6/26/13 at 2:21 p.m. MST, Consultant F reported that he/she lacked awareness that staff needed to monitor residents, such as resident #22, for targeted behavioral monitoring while taking Seroquel and Zoloft.		dents,					
	The facility failed to ensure that the pharmacy consultant reported irregularities to the attending physician and director of nursing that staff failed to monitor resident #'22s targeted behaviors while he/she received Seroquel and Zoloft.							
	Status MDS (Minimur reported the resident others and sometimes understood with seve MDS reported during * left the facility to an * returned to the facil * displayed signs of r depression, * experienced delusion * displayed physical * displayed physical * 6 days * displayed verbal be * rejected cares from	rely impaired cognition. the 7 observation days acute hospital on 5/2/1 lity on 5/30/13 moderately severe ons, behaviors toward others	nt ds . The standard in the st					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E071		B. WING		07/02/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
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					DEFICIENCY)		
F 428	8 Continued From page 69			F 428			
	clinical condition						
	* received antipsycho	otic medications 7 days					
	Posidont #10's 6/13/	13 Cognitive Loss CAA					
		ent) summary reported	the				
	resident transferred to						
	psychiatric hospital and since his/her return had						
	acted agitated and experienced a functional						
	decline with his/her activities of daily living.						
	Resident #19's 6/13/13 Mood and Psychotropic						
	Drug Use CAA summaries reported the resident						
	received Seroquel (an antipsychotic medication)						
	and noted the resider	nt "is easily excitable ar	ıd				
	cries very easily" duri	ing the observation peri	od.				
	Resident #19's 3/4/13	3 care plan informed sta	aff				
	that the resident had	a set routine and becar	ne				
		in advanced of upcomi	_				
	• •	nts and tended to either					
		ons in his/her cheek an					
		f not monitored closely. staff to monitor for worse					
	-	s and notify the nurse w	- 1				
	_	nysician. The care plan	I				
		nitor for possible side e					
		equences related to the	I				
		inistration) Black Box					
	_	of Seroquel and that th	I				
	•	ented behaviors every s	I				
	and reported to the p	hysician if concerns are	ose.				
	Resident #19's 5/30/	13 readmission physicia	ın's				
		rs to increase Seroquel					
		00 mg orally every day	for				
		ajor mental illness that					
	· ·	e episodes of severe h	_				
		th increased the original					
	6/11/12 order of 100	mg dally.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBE		LIA		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	17E071			B. WING		07/02/2013	
NAME OF PROV	IDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
GREELEY C	COUNTY HOSPITAL	LTCU		RD PO BOX E, KS 6787			
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R M re * d tr 9 * d d fare 5 R e b fc p R m 4 d c w h tr tr h D M c L a D C	Monitoring Intervention evealed: April 2013: the resident state of the resident to the resident to the resident distressing behaviors and the resident distressing behaviors documented the resident displayed not state of the resident record for targonical record for targonical record for targonical record for the resident record for the res	19's "Depression/Behavion Monthly Flow Record sident displayed no is throughout the month ransferred to an acute unit on 5/2/13 ident displayed no is 5/1/13 and 5/2/13, stated at as "OOF" (out of the state of the	even ff ne e e on ed uel rs. ant 2 and 's bring 27/13, ident .m. 9 and wed MST,	F 428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
	17E071			B. WING		07/0	2/2013	
	OVIDER OR SUPPLIER COUNTY HOSPITAL	LTCU		ESS, CITY, STA RD PO BO) E, KS 6787	(338			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 428	such as resident #19, monitoring while takin. The facility failed to e consultant reported in physician and directo to monitor resident #1 he/she received Sero. Resident #24's 4/30 Data Set) Assessment understands others a understood with mode. The MDS reported the behaviors, no delusion received antipsychotic medications for 7 of the Resident #24's 5/1/13 Psychotropic Drug Us Assessment) summan received Zyprexa (an and Zoloft (an antider the resident had rand with "very agitated beto the facility that now controlled, and the beto the physician attempt medication dosages. Resident #24's 6/3/13 monitor for the potent adverse consequence Drug Administration) the resident received care plan instructed sof his/her overall consuicide, the charge no a behavioral monitor.	for targeted behaviorally Seroquel. Insure that the pharmace regularities to the attentroof nursing that staff falg's targeted behaviors quel. Insure that the pharmace regularities to the attentroof nursing that staff falg's targeted behaviors quel. Insure that the pharmace regularities to the resident deprice the resident deprice and and him/herself the resident displayed not not be resident displayed not not and antidepressant the reside antidepressant medication, the reside antipsychotic medication and prices and medications that it is a these medications that is a these medications that is a the reside antipsychotic medication and the reside antipsychotic medication and these medications that is a care plan instructed staff to reduce these as a care plan instructed staff is a side effects and/or as of the FDA (Food an Black Box Warnings who Zyprexa and Zoloft. The taff to monitor for worse the side of the resident plants and zoloft. The taff to monitor for worse the resident plants and zoloft. The taff to monitor for worse the resident plants and zoloft. The taff to monitor for worse the resident plants and zoloft. The taff to monitor for worse the resident plants and zoloft. The taff to monitor for worse the resident plants and zoloft. The taff to monitor for worse the resident plants and zoloft.	ey ding iled while mum on. Ind on sion sion en	F 428				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
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F 428	orally twice a day for mental disorder characonfusion) with behavior start date of 7/2/12 armedication) 50 mg or depression (abnorma characterized by exagsadness, worthlessnestart date of 5/27/12. Review of resident #2 "Depression/Behavior Monthly Flow Record experienced one epis shift with an intervent no change in outcome of the target behavior the resident received lacked monitoring of the Review of resident #2 monthly medication resident with a resident pehaviors while the resident shadow of the resident form of the target behavior of the target behavior form of the target behavior form of the target behavior of the target behavior form of the target behavior of the target behavior for the resident pehaviors while the resident behaviors while the reand Zoloft. During an observation MST (Mountain Stand calmly in his/her room his/her spouse.	the could notify the last physician's orders lers for Zyprexa (antion) 2.5 mg (milligrams dementia (progressive acterized by failing menvioral disturbances with ad Zoloft (an antidepresally every night for I emotional state gerated feelings of ess and emptiness) with each state grant and an emptiness with each state grant and emptiness with each state grant and emptiness and emptiness with each state of paranoia on the ion of "one to one" visite. The form lacked ment they hoped to control of the experimental eview between 6/27/12 mentation that he/she esident received Zyprexal and Coloft, and experimental eview between 6/27/12 mentation that he/she esident received Zyprexal and Coloft and experimental eview between 6/25/13 at 10:31 and dard Time), resident #2 mas he/she conversed in 6/26/13 at 2:21 p.m. In 6/26	ion night and ntion while d s. nt's and geted ka .m. 4 sat with	F 428			
	Consultant F reported	that he/she lacked					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
17E07		17E071		B. WING		07/	07/02/2013		
GREELEY COUNTY HOSPITAL LTCU 56			506 THI	ADDRESS, CITY, STATE, ZIP CODE THIRD PO BOX 338 BUNE, KS 67879					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 428	awareness that staff needed to monitor residents, such as resident #24, for targeted behavioral monitoring while taking Zyprexa and Zoloft. The facility failed to ensure that the pharmacy consultant reported irregularities to the attending physician and director of nursing that staff failed to monitor resident #24's targeted behaviors while he/she received Zyprexa and Zoloft. - Resident #17's 5/13/13 physician order sheet included a diagnosis of hypertension (elevated blood pressure) and orders for Propanolol 10 mg (milligrams) 1 1/2 tablets twice a day and Lasix 60 mg. daily (both anti-hypertensive medications used to lower the blood pressure). Resident #17's 3/23/13 quarterly MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 10 which indicated moderately impaired cognition and required limited assistance of 1 person for activities of daily living. The resident received diuretic therapy during 7 days of the assessment period. The resident's 9/20/12 CAA (care area assessment) summary for activities of daily living revealed the resident required 1 person assistance with a walker for mobility. Resident #17's 4/2/13 nursing care plan included interventions and boxed warnings related to the use of Propanolol and Lasix.		y ding iled	F 428					
			ed O mg six ions						
			e of nition or d						
			iving						
	Standing orders dated 4/4/13 directed staff to notify the primary physician if a resident's systolic blood pressure (top number) registered less than								

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 17E071 B. WING 07/02/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **GREELEY COUNTY HOSPITAL LTCU 506 THIRD PO BOX 338** TRIBUNE, KS 67879 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 428 F 428 Continued From page 74 90 mmHg (millimeters of mercury) or greater than 170 mmHg and if the diastolic blood pressure (bottom number) registered less than 50 mmHg or greater than 100 mmHg. Review of resident #17's vital signs record revealed a blood pressure of 182/80 on 4/22/13 and 189/98 on 4/26/13. Review of the clinical record lacked any documentation that staff notified the physician of the elevated blood pressures. Review of consultant pharmacist F 4/30/13 monthly medication review lacked identification of resident #17's elevated blood pressures. During an observation on 6/25/13 at 5:30 p.m. MST, resident #17 ambulated in the hall with a steady gait with assistance of direct care staff P using a gait belt and a walker. An interview on 6/25/13 at 12:28 p.m. MST with licensed nurse B confirmed the nurses used the blood pressure parameters in the facility standing orders for physician notification of abnormal vital signs. He/she stated when a resident had an elevated blood pressure, physician notification should be documented in the nurses' notes. Licensed nurse B confirmed resident #17's clinical record lacked documentation of notification of the resident's elevated blood pressures on 4/22/13 and 4/26/13. During an interview on 6/25/13 at 2:22 p.m. MST, consultant pharmacist F stated he/she looked at trends of elevated blood pressures and was not aware of resident #17's elevated blood pressures on 4/22/13 and 4/26/13. The facility failed to ensure the consultant

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	17E071			B. WING		07/02/2013			
GREELEY COUNTY HOSPITAL LTCU 56			506 THI	T ADDRESS, CITY, STATE, ZIP CODE 6 THIRD PO BOX 338 RIBUNE, KS 67879					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	TION SHOULD BE COMPLETIC DATE			
F 428	Continued From page 75 pharmacist identified drug irregularities related to blood pressure monitoring for resident #17 who received antihypertensive medications.			F 428					
F 431 SS=D				F 431					
	a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliatio records are in order a controlled drugs is ma reconciled. Drugs and biologicals labeled in accordance	officient detail to enable in; and determines that and that an account of a aintained and periodical is used in the facility must with currently accepted.	an drug all lly						
	professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.								
	facility must store all locked compartments controls, and permit of have access to the keep to be access to the keep to b	tate and Federal laws, to drugs and biologicals in a under proper temperationly authorized personneys. Tide separately locked, compartments for storaged in Schedule II of the Abuse Prevention and not other drugs subject the facility uses single unition systems in which to imal and a missing dos	n ture nel to ge of to unit he						

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	17E071			B. WING		07/02/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
GREELEY	COUNTY HOSPITA	L LTCU		RD PO BOX E, KS 6787			
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F 431	Based on observation review, the facility fabiologics under proproduction of facility fabiologics under facility fabiologics under facility fabiologics under facility fabiologics fabiolo	s not met as evidenced to a census of 26 residents on, interview, and record ailed to store drugs and per temperature controls, the 26 residents. (Residents of the facilities nursing wor at 11:00 a.m., for the aled resident #2's Forted on for osteoporosis) store internal temperature grees F (Fahrenheit) on egrees F on 6/25/2013. The medication ternal after the facilities of 47 degrees F on 6/19/2013. The medication should be a facilities of 47 degrees F on 6/19/2013. The medication should be a facilities of 46 degrees F. Discard if frozen. Contact e. Legrator. The medication Temperature is medication to the degree of the facilities	s. The with 13 ation uld card Lilly if ature	F 431			
Interview with administrative nurse A on							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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GREELEY COUNTY HOSPITAL LTCU 506 T			506 THIF	DDRESS, CITY, STATE, ZIP CODE CHIRD PO BOX 338 UNE, KS 67879					
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F 431	aware the temperatur for medication storage acceptable range. Nu the required temperat medication Forteo.	n. revealed he/she was es of the refrigerators use were not within an rse A lacked awarenes cures for the storage of tore drugs and biological	s of the	F 431					
	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This Requirement is not met as evidenced by: The facility had a census of 26 residents with one kitchen that served all the residents. Based on observation, interview, and record review the facility failed to keep a sanitary environment within the kitchen by not keeping the floors clean.		ΓABL	F 465					
			n one						
	subsequent visits to that 11:15 a.m. and on revealed large darker and grime around the kitchen dishwasher, that racks in the dishwasher.	n 6-24-13 at 10:00 a.m. he facility kitchen on 6-6-26-13 at 2:00 p.m. hed areas of wax buildu following: the legs of the legs of the clean dister room, the legs of the the preparation area in	25-13 lip ne h						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E071		B. WING		07	/02/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
GREELEY	COUNTY HOSPITA	L LTCU		RD PO BOX E, KS 6787			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEI REGULATORY C	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 465	During an interview Dietary staff L state kitchen floors daily. did not have moppir the cleaning schedu kitchen floor needed remove the darkene During an interview maintenance staff G the kitchen floors. H deep cleaned aroun to be deep cleaned He/she further state cleaning schedules cleaning of the kitch floor needed to be of yearly. Record review of the revealed no schedu cleaning of the kitch The facility failed to	on 6-26-13 at 5:00 pm, d staff sweep and mop the He/she further stated her and sweeping the floor lies. He/she confirmed to d a thorough cleaning to ded areas. on 6-25-13 at 5:30 pm, deconfirmed the condition le/she stated the floors with a year ago and scheding again next month in July and he/she did not keep are that pertained to the deconfiction. He/she stated the sleaned more often than the kitchen cleaning schediled wax removal or deep	vishe virsion he of vere uled virsion he he	F 465			